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ABSTRACT

Presented is the final report of a project to demonstrate educationally relevant approaches to assessment of and prescription for severely handicapped children (0 to 21 years old) within an existing multidisciplinary diagnostic facility, the Central Arizona Child Evaluation Center. Part I provides introductory information with a definition of transdisciplinary assessment, an overview of the demonstration project, and a review of the evaluation process used before project implementation. Outlined in Part II are changes which took place in process (such as introduction of a case management system) and in structure (including expansion of the funding base and funding sources) which occurred as the transdisciplinary approach to assessment evolved. Discussed in Part III are the composition of the team and a description of the children served, the clinic process (which includes intake and case development, two assessment phases, and staffing and follow through), the parent resource library, the center's bilingual capacity, and the roles of the family and the school. Briefly discussed in Part IV are such future needs as the expansion of the natural settings team to include representatives of the psychoeducational disciplines. Appended materials include forms used at the Center, the advisory council and executive board by-laws, a case history, a list of frequently used instruments, and questions educators should ask following assessment. (SBH)

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Transdisciplinary Evaluation of Children:

Final Report of the Southwest Regional Resource Center's Involvement with the Central Arizona Child Evaluation Center

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PREFACE

Very few of the children identified as handicapped will flourish in the traditional classroom without some type of special support services. The special needs of each handicapped child arise from the handicap itself, from the degree of severity, from the child's experiential background--in the home, the community and the school--and from the immediate circumstances surrounding the remediation or habilitation program. Each child carries within himself a unique challenge, and the trends in educational laws, and hopefully within educational practice, have increasingly honored the uniqueness of each child in need.

The legislation that established Regional Resource Centers (Part C, Section 621, Public Law 91-230, Education of the Handicapped Act) marks a formal step toward this increasing attention to the individual needs of individual handicapped children. Regional Resource Centers have a general charge to ". . . develop and apply the best methods of appraising the special educational needs of handicapped children. . ." This report, Transdisciplinary Evaluation of Children, provides information from the third demonstration supported by the Southwest Regional Resource Center (SRRC) over a seven-year history, all three in response to the need to develop and apply new methods of serving handicapped children.

While this document concerns educational assessment and programming for relatively severely handicapped children, the SRRC's first demonstration was aimed at providing better services for handicapped children who were in regular classrooms--children who were mildly to moderately impaired. The first demonstration, the stratistician model, was developed in response to Utah's priority of providing support to regular education teachers who were serving handicapped children in the regular class. (At that time, the region served by the RRC was different, and it was called the Rocky Mountain Regional Resource Center.)

The stratistician model involved placement of a specially trained special educator in a school facility to provide

support services to the other teachers. The model was demonstrated for three years. During the first year, six stratisticians were placed in schools with different types of populations--rural, urban, transient, stable, etc. The second year, two more stratisticians and two more schools were added. During the final year, seventeen special educators from eleven Utah school districts were trained during the summer and provided backup support from the SRRC staff the ensuing school year in order to test the model with district-selected persons. Then a change in Utah school rules and regulations mandated that all support personnel had to have children assigned to them in order to generate funds. This unexpected variable confounded the evaluation design, but children and teachers from the eleven schools and two control schools participated in pretests and posttests.

Two documents were generated from the stratistician demonstration. Information for Inservice Training Development: A Collection from Field Efforts of the RMRRC was written for inservice trainers of teachers. The document is now available through an ERIC reprint (ED 138 025, with 390 pages.) A limited number of copies of the second document are available from the SRRC: Special Education Delivery Alternatives: Changes Over Time in Teacher Ratings, Self-Image, Perceived Classroom Climate and Academic Achievement Among Handicapped and Nonhandicapped Children.

The second major SRRC demonstration involved placement of two master-level special educators in a special school for the moderately and severely handicapped in Salt Lake Valley. The two were charged with identifying and defining the processes needed to get programs underway for more seriously impaired children. The resulting document, Establishing Services for the Severely Handicapped in Public Schools, is available through ERIC paper copy or michrofiche (ED 129 034); the document contains 290 pages.

This manual, Transdisciplinary Evaluation of Children. . . reflects SRRC involvement in a diagnostic clinic for moderately and severely handicapped children. Prior to the placement of the SRRC educational consultant, a medical emphasis prevailed at the Central Arizona Child Evaluation Center (CACEC). While this method of diagnosis provided widespread service to handicapped children and their parents, the educational component was missing. The Arizona State Director of Special Education, in conjunction with the Region 3 Management Board, requested that the SRRC place a staff person there to help clarify

and demonstrate the educational implications of the diagnoses performed at the center. Diane Renne, who filled this role at CACEC, and who also helped appraise and develop programs for handicapped children seen at the center, prepared this report based on her two years' experience at the CACEC.

The State Directors of Special Education in Region 3 (Arizona, Colorado, Nevada, New Mexico, Utah and the Bureau of Indian Affairs) requested that the SRRC's final report on their involvement with the CACEC identify process changes that occurred and briefly discuss the need for and consequences of these changes. Information about the change process comprises the main narrative of this report; records from a fictitious handicapped child's journey through CACEC illustrate current processes and procedures.

The State Directors also requested that Dr. Renne include suggested questions that educators should ask diagnosticians from various disciplines following the assessment of a handicapped child. Professionals from the disciplines represented at the CACEC prepared the question lists, which appear as Appendix E (p. 89). Other appendices contain forms used at the center, frequently used assessment instruments, by-laws of the policy and consumer advisory boards, and a case history of a child assessed at the CACEC.

This document, like others developed and disseminated by the SRRC, is seen as one step in a dynamic process of providing more effective appraisal and programming services for handicapped children. Educators who read this book are urged to utilize suggested procedures that lend themselves to upgrading appraisal methods for handicapped children, to modify those which do not quite fit the structure or delivery pattern, and to continue to explore better, more effective ways to provide exemplary diagnostic services to the severely handicapped.

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TRANSDISCIPLINARY EVALUATION OF CHILDREN: FINAL REPORT OF THE SOUTHWEST REGIONAL RESOURCE CENTER'S INVOLVEMENT WITH THE CENTRAL ARIZONA CHILD EVALUATION CENTER

PART I: INTRODUCTION

Comprehensive assessment of children with severe and/or multiple handicaps is a complex and costly process, yet such assessment is crucial to the ability of schools to provide adequate educational services to this population. However, it is not reasonable to expect that most schools could provide such comprehensive diagnostic services directly because of the costs; also, the severely handicapped represent a relatively low-incidence population and, furthermore, one which is quite heterogeneous in composition. Therefore, the most effective and efficient way of providing such services would appear to be through a single agency which could serve a larger population base than would be encompassed by any local educational agency.

For the past twenty years, there have existed throughout the country a number of multidisciplinary diagnostic clinical facilities, intended for the diagnosis of mental retardation and other handicapping conditions. Such centers have played an important and helpful role in the differential diagnosis of handicapping conditions. However, the information generated in such centers has not often been optimally useful to educators. When the focus of evaluation is diagnosis (i.e., labeling) too often little attention is paid to defining specific abilities and disabilities, or to relating those abilities and disabilities to a specific plan for habilitation, education or training.

Despite this rather significant weakness, there are advantages other than efficiency and cost effectiveness to utilization of multidisciplinary clinical facilities. When such centers operate optimally, the mass of medical, psychological and behavioral information which is pertinent to the problems of a multiply handicapped child can

be integrated to be more informative for professionals and more meaningful for parents. When specialists work in a setting where information is shared, any one individual's interpretation of an observation may be modified by the information available from another specialist, thus yielding a more accurate assessment.

Definition of Transdisciplinary Assessment

Currently professionals use a number of terms to describe the process whereby a child receives diagnostic services from a team composed of members representing the medical, social and developmental professions. Terms such as multidisciplinary, interdisciplinary and, lately, transdisciplinary, are used with many connotations. People who use the same word may be implying different processes; conversely, they may use different words to describe similar processes.

For purposes of this document, the words "multidisciplinary" and "transdisciplinary" will be used to refer to two separate approaches to evaluation; the use of "interdisciplinary"will be avoided. Multidisciplinary is used to describe an essentially serial evaluation process wherein a child is evaluated, assessed or tested by individual members of a team over some period of time. Typically, each team member then generates a "discipline report" that describes the specific diagnostic studies completed, provides a diagnostic impression, and recommends certain courses of action based upon the results. At some point, team members meet to share the information they have gathered. Depending upon the setting and the individuals involved, the information will be more or less integrated into a composite picture of the child, his functioning and his needs. The information is then shared in some manner with the child's family, his primary physician, the persons responsible for his training or education, and any other persons or agencies involved with the child and family.

The transdisciplinary process, on the other hand, is one in which representatives of the various disciplines contribute their individual expertise in addressing a specific set of concerns. The transdisciplinary process assumes the existence of a greater complementarity of expertise and it also less rigidly defines which specialist may address which aspects of a child's functioning. For example, it is assumed that not only the speech and hearing clinician but also the physician, psychologist, social

worker, etc., may make valid observations about the child's communicative abilities. The goal is not to simply add or layer information, but to synthesize the data from all disciplines. Sequencing of evaluations is seen as important and varies as a function of the set of specific problems or concerns to be addressed. Representatives of two or more disciplines may conduct joint evaluations in situations where it appears that problems may be interactive in their effect on functioning.

The Demonstration Project

In the Spring of 1975, the Southwest Regional Resource Center (SRRC), at the request of the Arizona Department of Education, Division of Special Education, initiated a demonstration project at the Central Arizona Child Evaluation Center (CACEC). The purpose of the project was to demonstrate educationally relevant approaches to assessment and prescription within an existing multidisciplinary diagnostic facility. The idea was not to simply add another layer to the assessment process in the form of an educator who would translate medical, social and psychological data into educationally relevant terms. Rather, the hope was to achieve more fundamental changes in the total process. The goal was to achieve a truly interactive, cross-disciplinary process, in which all specialists would orient their diagnostic activities to the generation of a comprehensive habilitation plan.

Such fundamental change is accomplished neither quickly nor by fiat. Rather, it occurs as a developmental process, each step building on the one preceding. While it is possible, with sufficient money and authority, to force immediate and dramatic change, the probability is great that such change will be adhered to more in form than in fact and will not persist beyond the tenure of the individual change agent.

Former Process

At the time the SRRC demonstration project began, the evaluation process underway at CACEC was serial and multidisciplinary in nature. The target population was defined as "children suspected of being mentally retarded." All children were seen by a professional from each discipline in the clinic; the only differentiation in the assessment

process lay in the numbers and kinds of medical specialty consultations which might be deemed necessary for an individual child. Since the purpose of the center was the diagnosis of mental retardation, psychological evaluation in the form of an IQ score was considered to be the core of the evaluation.

When all testing and evaluation had been completed, a staffing was held with members of the diagnostic team plus a consulting neurologist and psychiatrist. If the child was in a school program, representatives of the school were invited to attend. Each discipline presented a summarized report of activities and impressions; following the reports, any discrepancies in performance or differences of interpretation were discussed. A decision might then be made to request further studies to resolve a previously unnoted problem or to obtain further pertinent information in an area of disagreement. More often, however, team members reached consensus and established a diagnosis. In most instances, recommendations were few and nonspecific. Most often the only recommendation relative to the child's education was "school placement in accordance with school district policy."

Within two weeks of the staffing conference, a staff member (who had been designated at the staffing) conducted an informal parent conference where the results of all evaluations were presented. If the child had been diagnosed as retarded, the degree of retardation was indicated (in terms of mild, moderate, severe or profound) and explained with the aid of a visual chart. Parents were not permitted to see the written materials in their child's chart, but were provided with a copy of the report of the parent conference. CACEC staff then sent copies of this report plus the staffing conference notes to the school, to the family physician, or to other individuals designated by the parents.

This mode of operation filled a needed and useful role in the community. However, the advent of a law mandating education for all handicapped children in Arizona gave rise to a new set of needs. The clinical process began to change in response to those needs.

PART II: CHANGES IN PROCESS AND STRUCTURE

Many changes occurred--both in the process and in the structure--as the transdisciplinary approach to assessment evolved at CACEC. The professional staff worked toward increased specificity of recommendations for education and habilitation, and the expansion of specialist disciplines in the clinic. Concurrently, an increased funding base was obtained and broader parental and school involvement was sought. The changes in process and structure interacted to bring about the transdisciplinary approach now utilized at CACEC. The step-by-step discussion that follows, however, examines each change separately.

Process Changes

Major Milestones in Process Changes (building from existing serial, multidisciplinary assessment)

1. Case manager system introduced.
2. First cross-disciplinary team established.
3. Open records and parent participation in cross-disciplinary staffing initiated.
4. Problem-oriented assessment and three-day clinic process established.
5. Cross-disciplinary teams expanded.
6. Current clinic process attained, including natural settings assessments, diagnostic classroom, and follow-through procedures.

The first major change aimed toward establishing transdisciplinary assessment was the initiation of a case mangement system. At the time a case was accepted for evaluation, an individual staff member was assigned as case manager. This individual's responsibilities were:

1. Conduct an initial meeting with the parents to establish goals for the evaluation; in essence, establish a contract relative to the kinds of information the parents want to obtain as a

result of the evaluation. Also, explain to the parents the clinic process and the purposes of the various studies to be scheduled.

2. Determine, on the basis of the parent interview and additional information, such as school reports, what disciplines need to see the child. Also establish the sequence of activities if that seems to be of likely significance.
3. Monitor the progress of the case, reviewing reports of all assessments as they become available. Arrange for any additional assessments if it appears necessary based on the expanding information. Communicate with the parents about any such actions and their purposes.
4. Conduct staffing and prepare final report of the full evaluation.
5. Conduct parent conference.
6. Follow-up with telephone call to parents two weeks after the parent conference.

Initiation of case management served several purposes. One was simply to give the parents a consistent contact person within the clinic--an individual who was responsible for their child's evaluation and to whom they could communicate concerns or ask questions. Another was to provide a system for identifying recommendations for further assessment while the evaluation was in process, rather than waiting until the time of the staffing.

As part of the effort to increase the transdisciplinary nature of the evaluations and the integration of information, joint evaluations by two or more disciplines began to be scheduled. Initially, this was based on the age of the child and the parental estimate of the child's functioning level. Later, expansion included such factors as the presence of a motor handicap or significant feeding problems. The rationale for joint assessments arose from an assumption of significant interrelationships among cognitive, linguistic and motor development levels, especially in the very young child.

The next major process change was the adoption of an Open Records policy and the concomitant opening of the staffing conference to parent participation. Respecting the fact that some parents might feel overwhelmed or uncomfortable in that situation, the policy established was to give parents the option of attending the staffing or of having a separate conference with a single staff member. The case manager explained the options during the initial meeting. Although most parents have elected to participate in the staffing, a steady proportion have preferred individual conferences.

Although the case management system had attempted to focus the evaluation on specific parental concerns and questions, it made little impact on the form or content of the assessment. A major change was initiated with the introduction of a problem-oriented format for recording and reporting information. Inservice training was provided for staff prior to initiation of the new procedures, which were adopted from problem-oriented medical record procedures.

The evaluation process began with a staff meeting at which problem statements were developed and staff assignments made. The problem list was based on information from an exhaustive parent questionnaire (pp. 50-57), which was developed by staff as a means of eliciting information which would identify problem areas and help to determine which disciplines needed to see a child. For example, even though two children might have an identical problem listed (e.g., slow motor development), the questionnaire might reveal different characteristics relative to motor abilities which would suggest need for assessment by different disciplines.

As the evaluation progressed, each evaluator wrote problem-specific notes rather than discipline reports. Thus, any individual might generate notes relative to several problems. Conversely, two professionals might jointly write a response to a single problem. The notes were in a standardized format which included: problem number and problem statement; the subjective description of the problem by the parent; objective information, such as test data, direct observation assessment, or interpretation of the objective data in terms of the problem; and a plan for treatment or remediation of the problem. (See pp. 65-69.)

This problem-oriented approach was incorporated into a three-day clinic process. On Monday, Tuesday and Wednesday of each week, three children were evaluated by all the appropriate clinical staff, including the pediatrician, audiologist, social worker, and designated members of the psychoeducational component (psychology, education, speech and language, physical therapy, occupational therapy). On Friday of the same week, staff-parent conferences for each of the children were held. This had some significant advantages, primary among them being the immediacy of feedback to the family and school. There was also the advantage, from the viewpoint of the staff, that each child was still freshly in mind. It was no longer necessary to rely on written materials after an interval of weeks during which as many as twenty additional children might have been seen. Thus it was possible for the staff-

parent conferences to center more on the discussion of problems rather than the presentation of reports.

There were also, however, some significant disadvantages to the three-day clinic process. The primary disadvantage was that outside medical studies and consultations were not scheduled until after the staff-parent conference. This meant that a second conference always had to be scheduled for each family. In addition, it was often necessary to reinterpret psychoeducational data and revise recommendations as a result of additional information, especially in areas involving sensory functioning.

An additional problem was the fact that the scheduling of all three conferences on a single day required that some be scheduled at times of the day when school personnel were not likely to be free to attend. Also, the scheduling left very little staff time for such activities as school visits to observe children in their classrooms or follow-through in the form of diagnostic teaching or therapy. A flow chart of this clinical process is illustrated in Figure 1.

Modifications of the process, designed to eliminate as many of these problems as possible, resulted in the clinical process currently in use which is illustrated later.

Structural Changes

Major Milestones in Structural Change

1. Funding base and funding sources expanded.
2. Executive Board established.
3. CACEC transferred to Department of Health Services and relocated at Children's Hospital.
4. LEA representative given voting membership on Executive Board.
5. Citizens Advisory Council established.
6. Advisory Council obtained voting membership on Executive Board.

Concurrent with the changes in the evaluation process were a number of structural changes which significantly affected the operation of the clinic. First among these was the expansion of the funding base, which enabled the broadening of clinical services. Until July, 1975, the CACEC had been funded solely through Title V, Maternal and Child Health. An overall cutback in levels of Title V funding required reduction of staff positions, but the addition of education

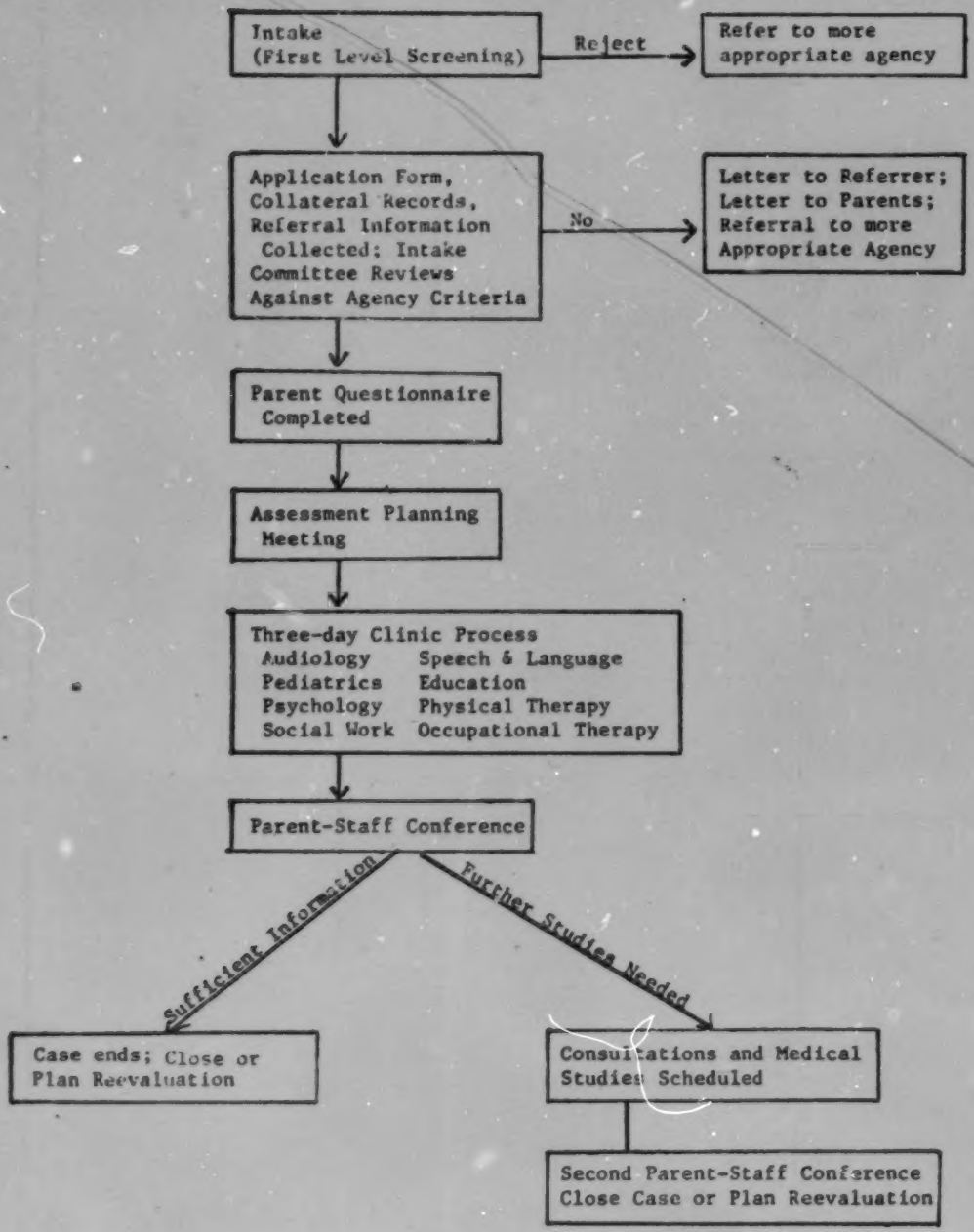

Fig. 1. Flow chart of former clinical process at CACEC.

monies (Title VI-B) enabled maintenance of the endangered positions, plus the addition of new kinds of services. Initiation of the SRRC demonstration project added the services of a special educator. The Bureau of Mental Retardation, Department of Economic Security, was involved through an in-kind contribution of the services of a social worker. These changes in the funding base facilitated the shift of focus from diagnosis to assessment and prescription.

In response to the complexities of administering a multiply funded service, a management board (later named executive board) was established. While direct administrative responsibility was vested in one state agency, this board functioned as a policy-setting body and monitored activities to ensure compliance with the requirements of the various funding sources. The board initially was composed of two representatives from the Department of Education, two from the Department of Health Services, one from the Bureau of Mental Retardation, and one ex officio member from the Southwest Regional Resource Center (SRRC).

Administrative responsibility for CACEC changed several times. When the SRRC demonstration project began, CACEC was administered by the Bureau of Mental Retardation. In July, 1975, it was transferred to the Division of Special Education. Then, as a result of a change in State Department of Education policies which specified that the Department would not function as a provider of direct services to children, CACEC was transferred in May, 1976, to the Department of Health Services--initially to the Bureau of Maternal and Child Health, and later to the newly established Bureau of Child Development. Subsequent to the transfer to Health Services, the physical facility was relocated at the Arizona Children's Hospital. This move provided some advantages for the center and its clients because the laboratory and x-ray facilities of the hospital, plus medical consultation through some of the specialty clinics, became available. Previously, a CACEC client might have gone to two hospitals and to three or four physician's offices in the course of an evaluation. Referral to and enrollment in Crippled Children's Services for long-term treatment and care when appropriate was also facilitated by this move.

Another significant change was the involvement of users of CACEC services in the operation of the center. This was accomplished in two ways. First, one of the executive board seats assigned to the Department of Education was delegated to a representative of the Greater Phoenix Curriculum Council. This provided the LEAs (local education agencies) with direct involvement in policies and

procedures of the Center. Soon after this, the SRRC conducted a Consumer Input Conference. Parents of current and former clients, representatives of public and private schools, physicians, and social services agency personnel were invited to participate. This was a working conference directed at defining user priorities, satisfactions and dissatisfactions with past services, and resources available in the community for enhancing services; also addressed was a preliminary redefinition of the target population. One of the most significant outcomes of the conference was the formation of a permanent Citizens' Advisory Council to CACEC. Membership of the Council includes parents, physicians, public school personnel, private school personnel, and representatives of social services agencies. The Council rules require that at least 51% of the membership be comprised of parents of developmentally disabled clients. The Council is perceived as having a variety of roles, including monitoring of client satisfaction, assistance to the Center in dealing with such problems as client access, and review of clinic processes. The chairperson of the Council holds a voting seat on the executive board, providing a second direct link for users to the operation of the CACEC. (Copies of the Advisory Council's Functional Procedures and the Executive Board By-Laws comprise Appendix B, p. 71.)

PART III: TRANSDISCIPLINARY CONCEPT AND PROCESS

Two basic assumptions underlie the transdisciplinary approach to diagnosis and prescription. The first is that when an individual has multiple handicaps, the effects of any one of those handicaps exacerbates the effects of all the others. With a deaf retarded child, for example, the impact of the deafness is different from the impact of deafness on a child of average or superior intellectual ability. The habilitation approaches will also differ because the limiting effects of intellectual retardation are compounded by the inability to use hearing for the acquisition of language.

The second assumption is that what is significant in the life of the child is not a set of diagnoses but a set of functional problems. Any one of these problems may arise from a number of physical, psychological and environmental factors. Given this, it is evident that no one individual or profession can adequately address the functional problems which are of concern to the family, the school, or to the child himself.

This is not meant to imply that there is no place for diagnosis. Certainly the total management of a child who does not walk at an expected age will be differentiated, to a large extent, on the basis of whether or not that child has cerebral palsy. Impairments of vision and hearing are diagnoses with obvious significance for habilitation planning. However, for the long term it is not the diagnosis, per se, which is significant, but the manner in which the disability affects the individual's capacity to manage the demands of his environment, including the learning environment of the school.

These assumptions give rise to the cross-disciplinary or transdisciplinary approach to assessment and prescription. The goal is the generation of an integrated plan for habilitation which can be implemented in the setting where the child ordinarily operates (home, and/or school). The method to reach the goal is by a sharing of information and skills across traditional disciplinary lines. This may mean one person working with the child incorporating information and direction from other professionals, or it may mean several professionals working simultaneously with

the child. This varies as a function of such factors as the age of the child and the nature of the specific problem being addressed.

The significance of such interaction can be illustrated by an incident which occurred during the assessment of a multiply handicapped adolescent girl. This girl was severely retarded and had cerebral palsy with a resulting progressive scoliosis; she also had visual problems related to poor binocular fixation and a resulting tendency to use only one eye at a time for fixation and tracking. During the program planning activities, the physical therapist recommended that, because of her scoliosis, the girl should be in an upright postion (in a wheelchair) only when necessary for feeding and transportation. Sidelying was the position recommended during programming activities designed to foster cognitive and linguistic development. The therapist's rationale for this was the differential effect of gravity on the curvature of the spine in the two positions. However, the optometrist quickly pointed out that the sidelying position, although the most desirable in preventing progressive physical deformity, was the least desirable from the viewpoint of visual function. Conversely, the best position for attending was upright sitting, the worst position for her body. Together, the physical therapist and the optometrist worked out an adapted position which was least detrimental to either aspect of the girl's habilitation. If this girl had been seen by the specialists individually, instead of in the team setting, the outcome might well have been two sets of conflicting recommendations which would have been left to the teacher to resolve. One or the other of the alternatives could have been chosen by the teacher only at some expense to the child in terms of her total well-being.

While transdisciplinary activities can occur within any structure of evaluation and planning, they are facilitated by the design or approach to assessment. In the preceding example, the eventual recommendation for positioning during programmatic activities could be given with more confidence because the issue arose at a time when the child was present. This meant that it was possible to try out several alternatives, assess immediately the effects of each from both points of view, and arrive at a satisfactory solution. While the issue would have come up in the staffing, any resolution would have been necessarily tentative.

Structuring the assessment process in a way that facilitates transdisciplinary activity has been a major focus of planning activity at CACEC. Much of the assessment activity occurs in a single setting and is conducted by teams of

professionals; the composition of a team for any one child will vary as a function of the problems to be addressed during the assessment. Later this assessment process will be described in detail and illustrated with the case of a fictitious child.

Composition of the Team and Description of Children Served

As has been noted in earlier discussion, the number of disciplines represented on the staff of the CACEC has expanded during the past two years. This has been partly due to the enlarged funding base and partly due to changes in the goals of the center. A copy of the goals and priorities of the CACEC follows. (Note that the assessment process is not yet referred to as transdisciplinary; the goals are dated December 10, 1976.)

GOALS AND PRIORITIES OF CACEC

The Central Arizona Child Evaluation Center wishes to inform all users of the CACEC service of the Center's service priorities.

Effective December 10, 1976, the Center will be guided by the following goals and priorities when considering applications for service.

GOAL OF CACEC:

To provide a comprehensive interdisciplinary diagnostic and prescriptive service for severely developmentally disabled children ages 0-21 as early in life as possible. A severely developmentally disabled child is one who has multiple handicapping conditions or one of such severity that it substantially limits one or more major life activities such as caring for oneself, walking, communicating and/or learning.

Developmental Disabilities include:

Mental Retardation
Epilepsy
Other neurological handicaps
Cerebral Palsy or other related neuromuscular diseases
Infants at high risk
Inborn errors of metabolism
Sensory impairment
Autism

PRIORITIES:

1. First: The severely developmentally disabled child who is unserved.
2. Second: The severely developmentally disabled child who is underserved.

The priorities will be met through:

1. Interdisciplinary diagnosis and prescriptive services at the CACEC.
2. Interdisciplinary diagnosis and prescriptive services in various natural settings including selected schools.
3. Parent training.
4. Professional and community education programs.

To those referring clients:

The Center cannot maintain treatment and education facilities at this time; however, it is essential that its service include not only diagnosis but the development of a habilitation program. This requires the active cooperation of the parents as well as the staff of those agencies making referrals. Therefore, agencies making referrals will be expected to indicate their willingness to work with the Center on the development and implementation of habilitation programs for a child.

The emphasis on generation of prescriptions for habilitation as well as the expansion of the target population from the original "suspected of mental retardation" require a greater range of expertise. The organizational chart, Figure 2, shows the variety of professionals currently working in the CACEC.

Clinic Process

Intake and Case Development

The flow chart in Figure 3, outlines the current clinical process. The first step is referral and intake. Contact with CACEC must be initiated by the child's parent or parent surrogate. If a referring individual or agency makes first contact with CACEC, they are advised to have the parents call the intake worker, assuming that it appears the child meets the criteria for services. The screening at this step is very general, and the great majority of contacts result in further action. In those few instances where the referral is clearly inappropriate, information about other, more appropriate services is provided.

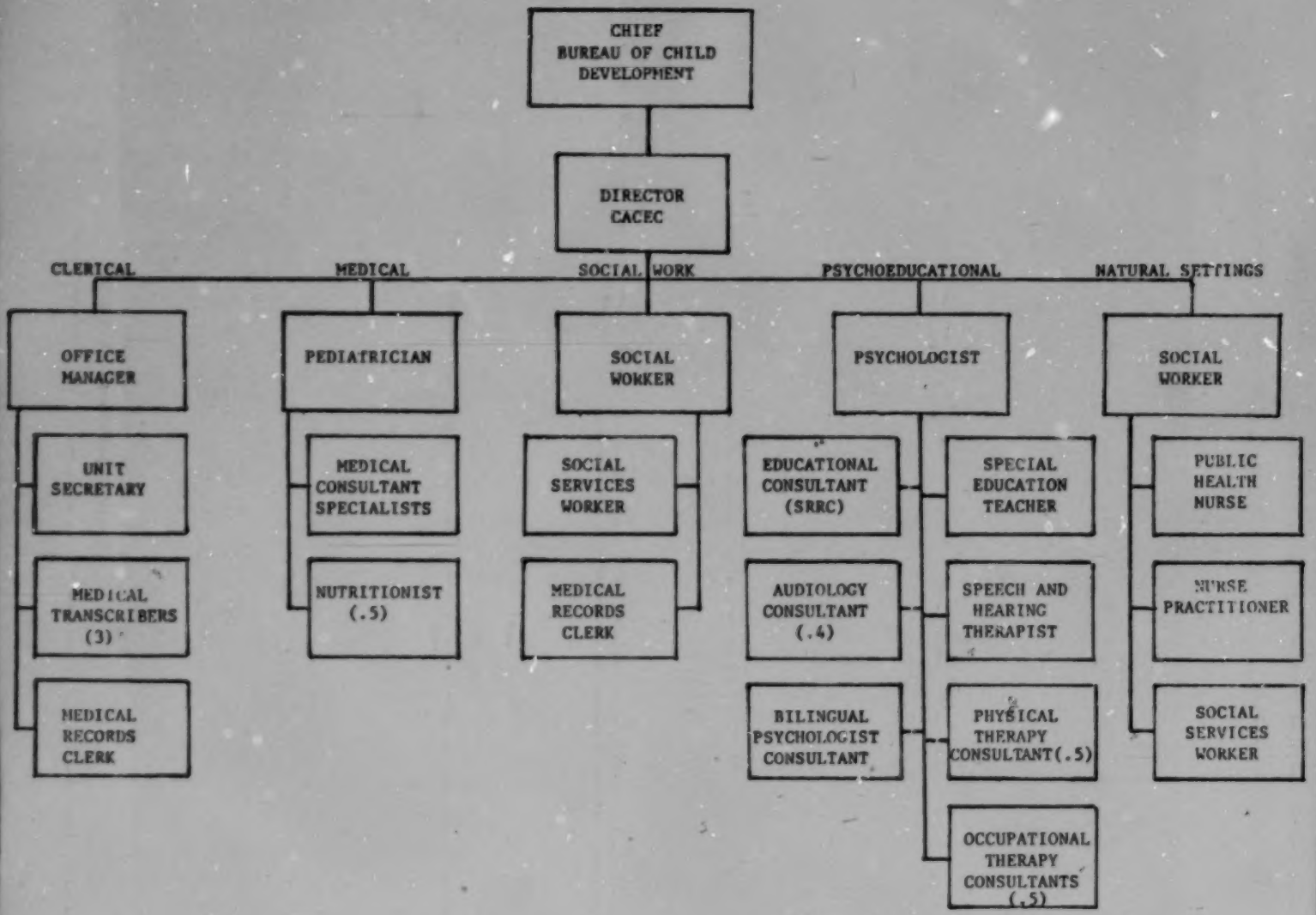

Fig. 2 Organizational Chart
Central Arizona Child Evaluation Center

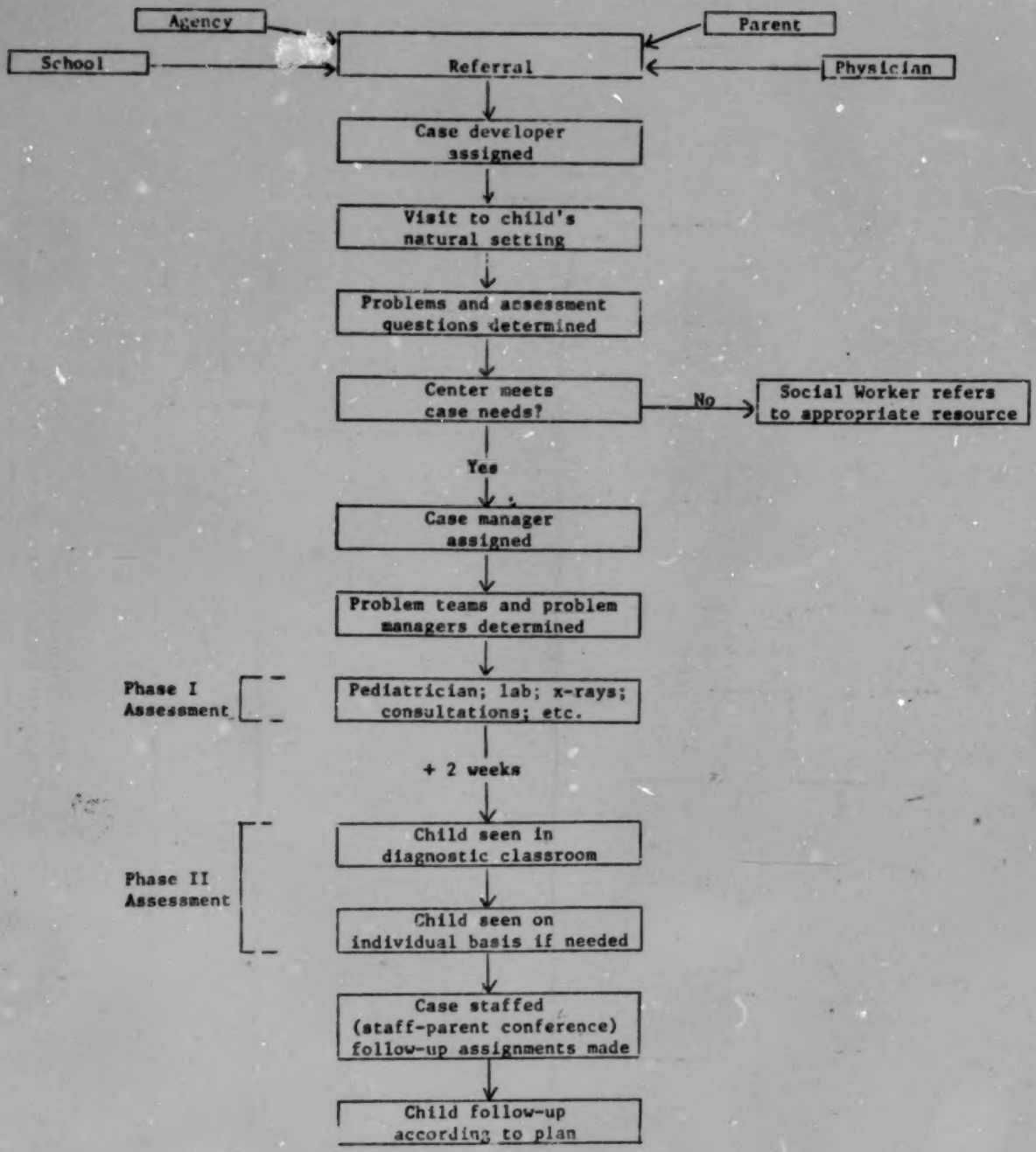

Fig. 3. Flow chart of clinical processes at CACEC

Following intake, an application for services and a parent questionnaire are mailed out. Copies of these forms are included in Appendix A. (It will be noted that the parent questionnaire is comprehensive, but not equally appropriate for all age groups. At the present time, this questionnaire is being revised and it is expected that there will be alternate forms for different age groups.)

Once the parents have completed the forms and returned them to the Center, a member of the Natural Settings Unit is assigned to be the case developer. This individual reviews the information, establishes a tentative problem list, and decides what collateral information is needed prior to proceeding with the evaluation.

Once all the information, including collateral records, has been obtained, the case developer schedules an interview with the family. Usually this interview takes place in the home, where a developmental screening (using the Alpern-Boll Developmental Profile) is also completed. When appropriate, the case developer also visits the child's school. After these meetings, the final problem list, together with assessment questions, is written. The problem list for Jimmy Smith, the fictitious child, follows. The problems described in this case are representative of the kinds of problems addressed in many of the real children who are seen at CACEC. (Replicas of the forms may be found in Appendix A. In actual practice, information is handwritten on the forms, but it is presented here in type for ease of reading.)

Problem Number	*Date Started*	*Date Discontinued*	*Problem Statement and Assessment Questions*	*Responsible Staff*
1	*6-10-77*		*Doesn't pay attention; sometimes stares into space and doesn't seem to hear or see. Is this a behavioral or medical problem? How can it be handled?*	*Pediatrician Psychologist*
2	*6-10-77*		*Cannot walk. What is preventing walking? What could be done at home and at school to further development in this area?*	*Pediatrician Physical therapist*

3	6-10-77	Speech is limited to a few single words, difficult to understand. What is the relationship to cognitive development and receptive language? How can communication abilities be improved?	Speech and language therapist Psychologist Audiologist
4	6-10-77	Considered to be a picky eater and very messy. How does this effect his nutritional status? To what extent are there motor control factors involved in his messiness? How does this relate to Problem #3? How can feeding skills be improved and variety of diet increased?	Nutritionist Speech and language therapist Physical therapist Occupational therapist
5	6-10-77	Has never been in school. What school readiness skills have been mastered? What kind of placement would be most appropriate to meet his educational needs?	Educator Psychologist
6	6-10-77	Family members have serious disagreements about how to manage child. How can parents be helped to resolve their conflicts and thereby provide more consistency?	Social worker Psychologist

Case Developer: _____ _____
Pediatric Nurse Practitioner

Smith, James Jr.

File # 9762

Based on information gathered at home and school, the problem list, and the collateral records, the case developer determines whether the center will be able to meet the child's needs. If it does not appear that the center is the appropriate resource, the case is turned over to the social worker for referral to a more appropriate agency.

Phase I Assessment

If the case does seem appropriate for CACEC, a case manager is assigned and the client is scheduled for Phase I Assessment (also referred to as baseline studies). If a medical examination has not been done by the nurse practitioner as part of the home visit, or if the physical examination performed in the home indicates possible medical problems, an examination by the pediatrician is scheduled. Nutritional, audiological and ophthalmological assessments are completed with all children. Depending on the findings of these three evaluations, laboratory studies, x-rays and medical consultations may be scheduled. In the case of Jimmy Smith, the following studies were initially ordered by the physician: x-rays of hips and spine, electroencephalogram, and skull x-rays. Hip x-rays indicated coxa valga deformity and subulation of both hips. The EEG was consistent with a convulsive disorder. Based on these two pieces of information, orthopedic and neurological consultations were requested. In Jimmy's case, a problem-oriented social work interview was also scheduled during Phase I, because of evidence of stress and discord in the family.

Phase II Assessment

Approximately two weeks after Phase I assessment is completed, Phase II assessment is scheduled. The head of the psychoeducational component is responsible for assigning a teacher or other staff member to assess each of the problems, based on the assessment questions and the data at hand. One member of the team assigned to individual problems is designated as the problem manager. It is this individual's responsibility to integrate the findings and recommendations of all members of the problem team and to produce the written report which presents the information from all team members in a coherent, concise manner.

Phase II assessment occurs in the diagnostic classroom. Older preschool and school-age children are scheduled for two three-hour sessions, one in the morning and one in the afternoon. Infants and younger preschoolers are scheduled for morning sessions only.

Three children participate in each of the classroom sessions. In the older group, there will be two new children and one child who is returning for a repeat visit or longer-term diagnostic teaching or therapy. In the younger group, there are typically two returning children and one new child. The staff who might be involved in a classroom assessment are:

special education teacher
SRRC educational consultant
psychologist
bilingual psychologist consultant
speech and language therapist
physical therapist
occupational therapist

A bilingual speech and language therapist is available as a consultant, but usually is not able to participate in the diagnostic classroom because of other commitments. Sometimes personnel from service programs which the child attends also participate, but again this is the exception rather than the rule. For school personnel especially, scheduling of such participation is difficult.

Each individual on the assessment team reports his information, observations and recommendations on a problem statement form. This form is submitted to the problem manager, who then synthesizes the information from all members and writes the final problem summary. To illustrate, the problem statement form drafted by the special education teacher and the problem summary sheet for one of Jimmy Smith's problems follows, along with the synthesized summary relating to all six problem statements. The problem sheets are preceded by a condensed copy of the report. (Replicas of all forms utilized at CACEC comprise Appendix A.)

REPORT OF INDIVIDUAL ASSESSMENT

Child's Name: James Smith, Jr.
Address:

Birthdate: March 2, 1971
Date of Report: July 29, 1977
CACEC File Number: 9762

Legal Guardian: Mr. & Mrs. James Smith, Sr.
Address:

Telephone:

CACEC Case Manager:_____ _____, M.S.W.

Child's Primary Language: English
Language Used in Home: English

PRINCIPAL REFERRAL SOURCE: School psychologist, District XYZ

PRINCIPAL REFERRING CONCERNS: Needs appropriate school placement for fall. School district does not have adequate resources to assess all his needs.

COMMUNITY PARTICIPANTS:
ASSESSMENT:

PARENT RESOURCE CONFERENCE:
School psychologist

COPIES OF REPORT PROVIDED TO:
_____ _____, Psychologist, School District XYZ
_____ _____, M.D. Family Physician
Arizona Crippled Children's Services

_____

_____

Problem Statement Form

Client's Name: Jimmy Smith B.D. 3-2-71 Case No. 9762
Problem No. 5 Evaluation Date 7-11-77 Report Prepared by _____
Position/Title Spec.Ed. Teacher Date 7-12-77
Assessment Participants Psychologist Speech & Lang. Therapist
Physical Therapist _____ _____ _____

Problem Statement: Has never been in school. What school readiness skills have been mastered? What kind of placement would be most appropriate to meet his educational needs?

Summary of Evaluation Findings: Jimmy was tested with Jedrysek's Psychoeducational Evaluation of the Preschool Child. With some adaptations of materials and response topography, Jimmy demonstrated skills at beginning kindergarten to first grade level in the following areas: perceptual matching; perceptual integration; short-term visual memory; receptive language; cognition. Visual-motor activities were performed slowly and with difficulty due to spastic involvement of the hands and arms. Short-term auditory memory could not be tested due to

difficulty with speech production. On the Boehm Test of Basic Concepts Jimmy scored at the 90th percentile for beginning kindergarteners. Quantitative concepts were especially strong. Concepts of space were the least well-developed, as could be expected in a child with a movement disorder.

The primary adaptations found to be useful were: utilization of a pointing response, pictures, and printed cards as alternatives to verbal responses; placement of table surface at shoulder level for work with pencils and crayons; use of a pencil holder for better hand position and better quality work.

Remediation Plan and Methods: At least initially, school placement would need to be in a program for physically handicapped children with normal learning ability, in order to provide for necessary therapy and adaptive equipment.

Establishment of a nonverbal communication system (perhaps a communication board utilizing Bliss symbols) must be a priority.

Initial reading instruction must be with a program which permits demonstration of comprehension without a demand for verbal response.

Demands for written responses should be minimized through the use of such things as cardboard markers, printed number cards.

When working on pencil and paper skills, an adapted pencil holder should be provided and the writing surface should be at shoulder level.

Follow-through Recommendations: School visit by special educator, physical therapist and speech and language clinician during the first month of school. Phone calls to school in December and April to check on progress. Further school visits, if needed, to be determined by outcome of telephone contacts.

PROBLEM # 5

Has never been in school. What kind of placement would be most appropriate to meet his educational needs? What school readiness skills have been mastered?

PROBLEM MANAGER: Special Education Teacher

PROBLEM TEAM:
Psychologist
Physcial Therapist
Speech and Language Clinician

ASSESSMENT STRATEGY: Observation, formal and informal testing in the Diagnostic Assessment Center.

Formal Tests Used: Columbia Mental Maturity Scale; Test for Auditory Comprehension of Language; Psychoeducational Evaluation of the Preschool Child; Boehm Test of Basic Concepts.

SUMMARY OF PRINCIPAL FINDINGS: On the Columbia Test of Mental Maturity (a standardized nonverbal test of intelligence) Jimmy obtained a mental age of 6 years 5 months, at chronologic age 6 years 4 months. This clearly indicates intellectual ability within the average range. This finding is further supported by the results of the Carrow Test for Auditory Comprehension of Language. Jimmy's ability to understand vocabulary and syntactic structures is appropriate for his chronologic age.

With appropriate adaptations of body position and response made, Jimmy was able to demonstrate mastery of basic school readiness skills and concepts. On the Boehm Test of Basic Concepts, he scored at the 90th percentile for beginning kindergarteners. Spatial concepts were the most difficult for him. Quantitative concepts were the strongest.

Jimmy was able to identify (i.e., point to when named) all upper case letters of the alphabet, and numerals 1 through 10. He was able to match numerals to corresponding quantities.

Both accuracy of pointing and ability to control a pencil were facilitated by elevation of the table surface to just below shoulder height. Ability to maintain a good sitting position at the table was facilitated by an adapted chair which helped to maintain flexion of the hips and knees and abduction of the legs.

Ability to respond verbally in instructional situations is very limited due to oral-motor involvement. This would be the least useful mode of response in a school situation.

Self-help skills are limited at this time due to motor difficulties. Jimmy requires assistance in toileting and dressing. He does manage a spoon and cup independently. Washing face and hands can be done independently when the situation permits sitting next to the sink. Independent mobility at this time is limited to bunny hopping, as Jimmy does not have a wheelchair which would enable him to move himself.

REMEDIATION OR CORRECTION PLAN:

1. *Enrollment in a classroom for multiply handicapped children of normal intelligence.*

Goal: Continued academic progress at a rate commensurate with age and intellectual ability; eventual integration into regular school classes and activities.

PRESCRIPTION FOR REMEDIATION OR CORRECTION:

A. *Use of instructional materials which provide for forms of response other than verbal.*
B. *Reduction of demands for written responses.*
C. *Adaptations of seating and writing surface to facilitate control when pencil/paperwork is required.*

FOLLOWALONG SCHEDULE AND PLAN

WHO: Physical therapist, speech and language therapist, special education teacher

INTERVAL: One month after beginning of school; then 3-month intervals until end of school

STRATEGY: School visit initially; telephone contacts thereafter with need for further school visits to be determined by outcome of phone contacts

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SUMMARY OF ASSESSMENT ACTIVITIES AND FINDINGS:

Pediatric and neurological examinations, plus laboratory studies, revealed the following biomedical inhibitions to learning: minor motor seizure disorder, manifested by the staring spells observed by parents; cerebral palsy of the spastic diplegic type. There was no evidence of a progressive disease process. The spastic cerebral palsy affects ambulation, hand usage, and oral-motor functions. The oral-motor involvement accounts for both feeding difficulties and difficulties in speech production.

Hearing and vision were tested and found to be within normal limits. Despite feeding problems, nutritional analysis indicated that the diet is adequate in all essential nutrients.

Psychological testing with a nonverbal instrument indicated average intellectual potential. Receptive language was demonstrated to be commensurate with age and intellectual ability. With appropriate modification of response modes, Jimmy demonstrated mastery of the concepts and skills required for success in kindergarten. A special school placement will be required to accommodate Jimmy's physical disabilities.

Parental conflicts resulted from differing interpretations of Jimmy's developmental problems. These conflicts are being resolved with increased mutual understanding of the problems. A need for long-term counseling is not anticipated.

PARENTAL REACTIONS/COMMENTS FOLLOWING CONFERENCE:

SIGNATURES OF PARTICIPANTS:

Child's Name: James Smith, Jr.
CACEC File Number: 9762

Of particular importance is the specification of a plan for follow-through from all assessments. Follow-through can assume a variety of forms including repeat visits to the clinic by the child, school visits by clinic staff, phone contacts with parents, teachers, or physicians, etc. Not only is the nature of follow-through activities specified, the individual(s) responsible and the anticipated intervals are also noted. The parents are given the opportunity to indicate which specific prescriptions and follow-through activities they feel are priorities and can be implemented. Staff schedules are arranged so that one full day each week is available for follow-through activities.

There are several advantages to conducting assessments in the diagnostic classroom setting. First, it provides an opportunity which might otherwise be difficult to arrange for the cross-disciplinary interactions which are considered to be of major importance. Second, the classroom-like atmosphere, because it is more familiar than the typical individual testing room, is often more comfortable for children. This increases the likelihood of professionals observing typical patterns of behavior and responses. This effect is enhanced by the fact that each child comes into the classroom for a minimum of two three-hour sessions, which provides the opportunity for greater familiarity with the staff as well as the setting. Thus, chances are enhanced for establishing rapport with the child, especially with the youngster whose initial response to strangers is one of caution or shyness.

The scheduling of the classroom sessions on different days of the week provides staff with the chance to review the information gathered and engage in informal discussion with other team members. This is a built-in opportunity for identifying areas which need further exploration, thereby expanding the range of assessment activities which are undertaken.

Staffing and Follow-Through

When Phase II assessment has been completed, a staff-parent conference is scheduled. If the child is in a school program, school personnel are invited to participate in this conference. It is at this meeting that the findings and recommendations related to all assessment problems are discussed. Parents and school personnel are encouraged to ask questions and to contribute to the discussion. Parental comments and reactions are recorded as part of the complete report of the assessment. In addition, the parents are asked which of the recommendations they feel can and should

be implemented and to indicate their willingness to carry out certain activities and cooperate in follow-through.

Planned follow-through can occur through one or several methods. Often, it may be only a telephone contact with the family or school to check on progress. If that contact indicates the existence of significant problems or failure to progress, further assessment and program revision may be undertaken. Another form of follow-through is periodic reassessment by certain disciplines. A typical interval for this is six months to one year; reassessment is most often utilized for children if there is reason to suspect that there may be significant changes in their rate of developmental progress following specific treatment or training.

Another form of follow-through is extended diagnostic teaching or therapy in the clinic. While this has not yet been done extensively, an expansion of this form of follow-through is planned for the immediate future. This will provide the opportunity for assessing the effectiveness of recommended interventions and allow for the generation of plans of demonstrated effectiveness prior to referral to community programs. It is anticipated that this form of follow-through will be used primarily with younger, multiply handicapped children, and that parent training will play a major role.

Parent Resource Library

With increased emphasis on follow-through, increased attention has been paid to parent training. The assumption has been that, at least with the preschool-aged child, the parent(s) will be the primary "teacher." Simply giving the parent verbal or written instructions and recommendations is considered inadequate, so children and their parents are brought back to the clinic for one or more training sessions following the final conference. The development of a parent resource library supports these training activities. This library includes written materials for parents on such topics as child development, child management and child health. In addition, there are toys, children's books and records, and physical therapy equipment for loan to families which do not have the financial resources to acquire recommended materials and equipment.

Bilingual Capacity

As would be expected because of geographic location, the CACEC serves a number of clients who are non-English-speaking or for whom English is not the primary language of the home. By far the majority of these clients are Spanish-speaking, although several Indian languages are also frequently encountered.

In the cases of those who speak Indian languages, it is necessary to ask that a bilingual friend or neighbor accompany the family to clinic appointments. Because of the frequency with which Spanish-speaking clients are served, the CACEC has contracted with a bilingual (native Spanish-speaking) educational psychologist on a half-time basis. This individual not only conducts assessments of Spanish-speaking and bilingual children, she is available to other staff to serve as an interpreter; she also conducts parent conferences with non-English-speaking parents. With bilingual families whose primary language is Spanish, she often completes follow-up interviews after the parent-resource conference to be sure that the parents have fully understood the information presented. This individual is also a valuable resource to the clinic staff in terms of interpreting such things as family structures and child-rearing practices in light of cultural norms.

Also available as a consultant, although less frequently used, is a speech pathologist who is also bilingual in Spanish and English. This professional would be utilized more often, but she has limited available time.

In addition to the bilingual services available within the clinic, close liaison is maintained with community programs which can help the non-English-speaking parent to access programs, services, and legal or financial assistance. These resources typically become involved at or immediately after the parent-resource conference. This helps to ensure that the family will be able to carry out the recommendations arising from the assessment.

The Role of the Family

The parents or parent surrogates are viewed as active participants in the diagnostic process. The parent role is central in establishing the goals of the evaluation. Parental concerns are, and must be, accepted and addressed seriously, regardless of whether the clinical team, the teacher, or anyone else involved with the child view

those concerns as legitimate. Similarly, the parent's perceptions of the child's developmental status must be accepted seriously as part of the data base upon which the assessment is built. Experience suggests that most often a parent's estimate of a child's functioning level closely approximates the results of formal testing. When there is a great discrepancy between these two pieces of data, it is necessary to look very closely at: a) factors which may have affected the validity of the testing, and, b) the functioning of the family unit, including parent-child relationships.

Historically, at CECEC as at many similar clinical programs, the results of an evaluation were communicated to the parents in an interpretive conference which followed some time after the professional staff conference. As parents have been viewed more as participants in the total evaluation, it has appeared more logical to include them in the transdisciplinary staffing (staff-parent conference). Other family members may also be involved, including siblings, grandparents, or any other members of the extended family who are closely involved in the care of the child. At times, especially with older children, the child himself may be included in all or part of the transdisciplinary conference.

An obvious fact dictates the major reason for family involvement in the full process: nearly all children live within the context of a family. Even those children who are residents of public or private institutions often have frequent contact with their families. The functioning of the family unit affects the child's development and, of equal importance, the child and his problems affect the functioning of the family. It has been documented that the presence of a handicapped child introduces stresses into a family situation. It is important that the results of the diagnostic/prescriptive process not be of such a nature as to introduce further stress or disruption into the family unit. It is all too easy for a team of relatively uninvolved professionals to generate a set of "best of all possible worlds" recommendations which simply cannot be accommodated within the family structure. At CACEC, an established, formal mechanism enables parents to respond to staff recommendations from the realities of the family unit. After the findings and recommendations pertinent to all problems have been presented and discussed, the parents are asked to indicate which of the recommendations they feel can and should be implemented. This becomes part of the final report of the assessment. Parents then sign the final report, indicating that they have read it, that the report

corresponds with their understanding of the conference, and that they have agreed to follow-through with certain activities.

The Role of the School

A large proportion of children referred for diagnostic services at a multidisciplinary clinic are referred by schools. Clearly, school personnel have a vested interest in the results of an assessment, whether or not the referral was made by them. This interest implies both rights and responsibilities:

Rights

1. Schools have the right to expect that their specific concerns about the child and his functioning in school will be a major focus of the evaluation process.
2. Schools have the right to expect that they will be involved in the evaluation process, particularly at the point where school-related prescriptions are being generated.
3. Schools have a right to expect that conferences will, whenever possible, be scheduled at times which will not be disruptive to the school day. Further, they should reasonably expect sufficient advance notification of the date, time and place of the conference to make necessary arrangements for attendance.
4. Schools have a right to expect that results and recommendations of the evaluation will be communicated to them in writing as well as verbally at the time of the conference (assuming parental consent is obtained).
5. Schools have a right to expect that all information, including medical diagnoses, which relate to or affect the child's school performance, will be communicated in terms that are understandable with the probable impact discussed fully.
6. Schools have a right to expect that clinical staff will follow up to determine the effectiveness of recommendations made and to modify those recommendations as necessary.

Responsibilities

1. When the school makes a referral to a diagnostic center, it is their responsibility to make clear

to the parents the reasons for the referral and the expected benefits of the evaluation.

2. The school has the responsibility to communicate as precisely as possible their concerns about a child's functioning and their expectations of the outcomes of evaluation.
3. The school has a responsibility to provide to the clinic pertinent records about the child, including results of assessments done within the school, when requested to do so in writing by the parents.
4. The school has the responsibility of ensuring that the written report generated by the evaluation is provided to the teachers and other personnel involved in the child's daily programming. Too often these reports are placed in a locked file in a central office and never seen by the personnel who most need the information.

PART IV: NEEDS FOR THE FUTURE

The developmental process underway at the CACEC will not end with the conclusion of SRRC participation. Although staff members feel strongly that the present model is most effective for providing diagnostic and prescriptive services to severely and multiply handicapped children, they are aware that the service delivery system is not ideal. Several factors constitute gaps in the delivery system; e.g.:

1. Inability to have the neurologist or psychiatrist participate in staffings.
2. Necessity of sending clients out to consultant offices.
3. Delay in getting consultant reports so that significant information is sometimes not available at the time of work in the diagnostic classroom.
4. Unavailability of consultant medical specialists for translation of findings into functional terms.
5. Unavailability of school personnel during summer.
6. Difficulty in defining "underserved," which requires a value judgment.

Several changes have been and are being considered as ways to elaborate or improve present services. Expansion of the natural settings team to include representatives of the psychoeducational disciplines is highly desirable. Often learning and behavioral problems are best assessed in the settings where they naturally occur. Certainly assessment in the child's natural settings can enhance the clinical team's ability to develop prescriptions which are relevant and realistic for the environments in which they will be implemented.

While present staff perform some assessments in the school and in the home, the staffing level does not permit general utilization of such assessment. Attempting to conduct assessments in natural settings with present staff would mean reducing the total number of children served to approximately one-third the present level.

The establishment of satellite centers has also been considered. The CACEC serves a large geographic area.

This means that often a total assessment must be compressed into a three-day period of time or that sometimes staff attempt to validly assess a child who is tired, restless or irritable from prolonged travel to the clinic. The establishment of satellite centers in smaller population centers of Central Arizona would help to reduce these problems. It would also enhance assessment and follow-through in natural settings.

Such centers would not be staffed with as many disciplines as at CACEC; in particular, the range of specialized medical studies would be limited. However, not all children need extensive medical workups. For those who do, there would still be advantages to having had the social and psychoeducational components of the assessment conducted in locations nearer to their homes.

To date, an adequate system has not been established for obtaining referral information from the referral agency or individual. Parents are asked to indicate who made the referral and to state the primary concern of that person. However, only occasionally are the referrers asked directly to state their concerns and expectations of the evaluation. This most often occurs when there is a question about the eligibility of the child. Also information is not given directly to the referrer indicating that the parent has contaced CACEC and whether the child was either accepted for services or referred to a more appropriate agency. Efforts have been made to develop forms which would request referral information and report on client acceptance, but to date acceptable ones have not been devised.

There is an additional need which is not directly related to the diagnostic prescriptive functions of the center. This relates to the funding base. Although CACEC has provided services to Arizona children for more than 20 years, center operations have never been supported by any state monies. Federal grant monies have provided the total operational funding. It would be most desirable to have at least a portion of service costs funded directly by the state. The Citizens Advisory Council to CACEC is most interested in this issue and may be the best vehicle for achieving state funding for the Center.

APPENDIX A

Forms Used at CACEC

Forms Used at CACEC

The forms and letters which are replicated here are those currently in use at the Central Arizona Child Evaluation Center. The sequence in which they are used may vary slighlty, or may be simultaneous, but they appear here in the usual order of use. Forms that become part of the client's permanent file and which are printed on both sides of a sheet are printed so that all records can be attached to the top of the file; thus, the first side is typed from top to bottom, the second side reverses the top and bottom of the first.

Multi-page forms are coded for easier understanding. For example, pages a-1 and a-2 were disseminated together, but only a-2 would go into the file. Page a-1 is included because it provides an overall view of the process. The following brief outline may be helpful:

a-1: Monitoring procedures
a-2: Individual case diary

b-1
and 2: Screening form (1 sheet)

c-1: Initial letter to parents, in which are enclosed:
- c-2 to c-5: Application for Evaluation
- c-6 to c-13: Parent Questionnaire
- c-14: Consent form for videotaping, etc; for participation of others in staffing conference; for release of client records to others

d-1: Parent-signed release for CACEC to obtain other records, including
d-2: Physician's prenatal record of mother, and
d-3-5: School observation form

e-1: Letter to parents informing them of Open Records policy

f-1: Problem Statements and Assessment Questions

f-2: Problem Statement Form (completed by individual and reflecting individual findings relative to one problem)

f-3, 4 (one sheet): Principal findings, prescription and follow-through related to one problem; compiled by problem manager from all team members' findings.

f-5: Summary of Assessment Activities and Findings, Parental Comments, etc.: summary of findings for all identified problems; prepared by case manager.

POLICIES AND PROCEDURES

CENTRAL ARIZONA CHILD EVALUATION CENTER
BUREAU OF CHILD DEVELOPMENT

TITLE: Monitoring Client Service Activities

EFFECTIVE DATE:

PREPARED BY: Daniel B. Overbeck, Ph.D.

ARPPOVED BY:

REVIEWED BY:

DATE:

POLICY

The CACEC monitors the progress of each client through the established service sequence to assure accurate and complete service within the shortest possible time.

PROCEDURE

1.0 The Individual Case Diary (see attached) is used to monitor each client's progress through the CACEC service sequence.

1.1 A separate form for each child is maintained by the Medical Records Clerk in a central register of cases open for services.

1.2 Case Developers and Case Managers are responsible for informing the Medical Records Clerk as progress is made in the processing of each case.

1.3 Activities reflected on the Individual Case Diary form can be considered progressive, i.e., the sequence of activities for a specific client should be reflected in a smooth undisrupted flow from the top of the form to the bottom.

2.0 By the 25th of each month, the Office Manager will provide the CACEC Director with a summary of client services. This information will be incorporated into the monthly reports to the Chief, Bureau of Child Development and the Executive Board.

3.0 Upon completion, each Individual Case Diary will be filed in the client's master file.

pw
7/8/77

	ACTIVITY	DATE COMPLETED	IDB FORM COMPLETED
CASE DEVELOPMENT	Initial inquiry & Contact Form begun		//////////
	Eligibility determined		1
	Case Number: Case Developer: assigned		//////////
	MRC starts case file		//////////
	MRC mails questionnaire, etc. to parents		//////////
	Parents return questionnaire and application, etc.		2
			3
	Collateral data requested:		//////////
	Collateral data requested:		//////////
	Collateral data requested:		//////////
	Collateral data requested:		//////////
	Collateral data requested:		//////////
	Parent/Resource planning meeting scheduled:		//////////
	Problem statements, Case Dev report and Rpt Cover Sheet		6
	Case Manager assigned:		//////////
	Case Developer notifies family of CM assigned		//////////
CASE MANAGEMENT	Pediatric exam (scheduled:)		9
	Audiological exam (scheduled:)		9
	Ophthalmological exam (scheduled:)		9
	Nutritional assessment (scheduled:)		9
	Social Service assessment (scheduled:)		9
	Laboratory/Procedures: cbc, us		9
			9
			9
	cat, eeg, ekg, x		9
	Consultant scheduled		9
	Consultant scheduled		9
	Consultant scheduled		9
	Consultant scheduled		9
	Consultant scheduled		9
	Pediatric report on file		//////////
	Audiological report on file		//////////
	Ophthalmological report on file		//////////
	Nutrition report on file		//////////
	Social Service report on file		//////////
	DAC - Problem #1		9
	DAC - Problem #2		9
	DAC - Problem #3		9
	DAC - Problem #4		9
	DAC - Problem #5		9
	DAC - Problem #6		9
	DAC - Problem #7		9
	IDB - Behavior Development Survey form	//////////	11
	Client Diagnosis established		5
	Parent/Resource Conference scheduled		9
	Community participants for conference notified		//////////
	Prescriptive plans accepted		//////////
	Followalong for accepted Plans scheduled		//////////

CENTRAL ARIZONA CHILD EVALUATION CENTER
SCREENING INFORMATION

CHILD'S NAME _____ BD _____ AGE _____

ADDRESS _____

_____ _____ PHONE _____

MOTHER'S NAME _____ FATHER'S NAME _____

SCHOOL _____ DISTRICT _____ GRADE _____

ADDRESS _____

REFERRAL SOURCE _____

WHY REFERRED FOR EVALUATION _____

_____

_____

WHAT PROBLEMS PARENTS PERCEIVE _____

_____

WHAT PROBLEMS OTHERS PERCEIVE _____

_____

WHAT OUTCOME DO PARENTS EXPECT FROM EVALUATION _____

_____

_____

BIRTH HISTORY

HOSPITAL _____

UNDER WHAT NAME _____ BIRTH WEIGHT _____

PROBLEMS DURING LABOR AND AT DELIVERY _____

_____

_____

DEVELOPMENTAL HISTORY (IF NEEDED)

HELD UP HEAD _____ MOS. ROLLED OVER _____ MOS. SAT ALONE _____ MOS.

CRAWLED _____ MOS. WALKED ALONE _____ MOS. TALKED _____ MOS.

TOILET TRAINED _____ YRS. DRESSED SELF _____ YRS. FED SELF _____ MOS.

Case Developer _____

Case Number _____

SCHOOL HISTORY

HOW IS CHILD DOING _____

PROBLEMS _____

_____

TEACHER'S NAME _____

HAVE PARENTS SOUGHT HELP PRIOR TO THIS FOR CHILD _____

AGENCIES INVOLVED WITH CHILD _____

_____

_____

TYPE OF PAST EVALUATION _____

_____

_____

CHILD'S DOCTOR OR CLINIC SITE _____

_____

HOME SITAUTION AS IT EFFECTS CHILD _____

_____

_____

WHO WILL BE INVOLVED IN THE PRESCRIPTIVE PLAN _____

_____

INFORMANT _____

TAKEN BY _____ DATE _____

ARIZONA DEPARTMENT OF HEALTH SERVICES

Division of Family Health Services

RAUL H. CASTRO, Governor
SUZANNE DANDOY, M.D., M.P.H., Director

Your request for services at the Central Arizona Child Evaluation Center has been received. If it appears to be the kind of problem we deal with, we shall let you know.

Our decision will be greatly helped if you will fill out the enclosed application form, parent questionnaire and sign the release forms where indicated; please return these in the self-addressed stamped envelope(s), also enclosed, as soon as possible.

Your application will be screened by a committee made up of the Center's professional staff. If they believe that we are the best agency to help, you will be given an appointment and the evaluation will take place six to eight weeks later. If we cannot help you, we will try to find another agency who can.

If you need any further information, please feel free to telephone us.

Sincerely,

Central Arizona Child Evaluation Center
244-9471 Extension 333

LH

Enclosures

CACEC 13
3/10/77

Case No. _____

CENTRAL ARIZONA CHILD EVALUATION CENTER
200 North Curry Road
Tempe, Arizona 85281
Telephone: 244-9471 Ext. 333

Date _____

APPLICATION FOR EVALUATION

I.

Name of Child _____ Sex _____ Age _____
Last First Middle

Current or Home Address _____

_____ Phone: Home _____ Work _____
City State Zip Code

Birthdate _____ Birthplace _____
Month Day Year City State

Hospital where child was born _____

Address _____
City State Zip Code

Maricopa County General Hospital # _____

Other Child's Hospital # if known _____

Name of mother's obstetrician _____

Address _____

School District _____

II.

(Check one)	Name (Last) (First) (Middle)	(Maiden)	Birth Date
FATHER:			
Step ___ Natural ___			
Foster ___ Grand ___	_____		_____
Adoptive ___			
MOTHER:			
Step ___ Natural ___			
Foster ___ Grand ___	_____	_____	_____
Adoptive ___			

Parent's Marital Status: ___ Married, date of marriage _____

___ Remarried, date of remarriage _____

___ Widowed ___ Separated ___ Divorced ___ Single

Religion _____ Race _____ Child resides with _____

Occupation of natural or surrogate parents (check one)

	Type of Employment	Place of Employment	Phone	Approximate Yearly Income
FATHER: Step ___ Natural ___ Foster ___ Grand ___ Adoptive ___				
MOTHER: Step ___ Natural ___ Foster ___ Grand ___ Adoptive ___				

Education of natural or surrogate parents (check one)

	Grade School	High School	College	Graduated(?)
FATHER: Step ___ Natural ___ Foster ___ Grand ___ Adoptive ___				
MOTHER: Step ___ Natural ___ Foster ___ Grand ___ Adoptive ___				

Military information: _____

Military Identification Numbers: _____

Medical insurance: ___ Yes ___ No

III.

Child's School History: Has attended the following schools (if none, write "none"):

_____

_____

Child presently attends (if none, write "none"): _____

Describe how child has adjusted to and succeeded in school experience:

_____

_____

_____

List all children in family, in order of birth (oldest first), including child to be evaluated.

	Name	Sex	Birth Date	School Grade
1.				
2.				
3.				
4.				
5.				
6.				

If you have more children list them on the back of this page.

*Are any of the children named having similar problems?

List all other Persons living in the home (not already mentioned).

Name	Relationship to Child

IV.

What person or organization suggested that you bring your child to this center?

What were their reasons for suggesting the evaluation?

What main problems does your child present?

Please describe your reasons for requesting an evaluation:

Please indicate what kind of help you would like from the evaluation:

Application for Evaluation of Child c-5

Has your child been seen in other clinics or agencies? ___ Yes ___ No

Has your child had an evaluation elsewhere? ___ Yes ___ No

If "Yes," please give details as to where and when:

_____

_____

_____

Names and addresses of doctors who have been consulted about this problem:

_____

_____

_____

V.

Check all the following items which concern you about your child's development. Please check with an X the problems you consider most serious and mark with an O those problems you consider not as serious.

Generally slow	_____	Overactive	_____	Poor coordination	_____
Cannot walk	_____	Nervousness	_____	Unable to feed self	_____
Cannot talk	_____	Fears	_____	Injures self frequently	_____
Not seeing well	_____	Nightmares	_____	Difficult to discipline	_____
Not hearing well	_____	Bad Temper	_____	Lack of toilet training	_____
Poor sleeper	_____	Disturbs others	_____	Cannot learn in school	_____
Restlessness	_____	in the home	_____	Fights with other	
Convulsions	_____			children	_____

Other Problems (not mentioned above): _____

_____

I am providing the above information in application for assessment, diagnostic, prescriptive and followalong services from the Central Arizona Child Evaluation Center.

_____
Signature of Parent or Legal Guardian

Name of person filling out application if other than parent or legal guardian:

_____ Relationship to child _____

Date of application _____

CACEC 3
5/2/77
lm

PARENT QUESTIONNAIRE

c-6

CHILD'S NAME_____ DATE_____ CHART #_____

I. MEDICAL MATERNAL AND FAMILY HISTORY

How many times has mother been pregnant? _____

How many live children do you have? _____

Has mother ever had a miscarriage or abortion? Yes___ No___
If yes, how many _____

Have any childred died? Yes___ No___
If yes, how many _____

Has mother had babies (other than this child) who were premature? Yes___ No___

Is the natural mother RH negative? Yes___ No___

What month of this pregnancy did the mother first seek medical care? _____

Did you smoke during this pregnancy? Yes___ No___
How much? ____packs/day

Did you drink alcohol (beer, wine or liquor) during this pregnancy? Yes___ No___
How many glasses/day? _____

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT THE MOTHER HAD DURING THIS PREGNANCY

____Nausea
____Dizziness
____Anemia
____Vomiting
____High Blood Pressure
____Infection
____Bleeding
____German Measles (mother)
____German Measles (other family members)
____Injury or accident
____Convulsions
____Unusual physical stress
____Unusual emotional stress
____X-rays to the abdomen
____Visits to doctor for pregnancy care
____Other illness
____Other injury

PLEASE CHECK MEDICATIONS TAKEN BY MOTHER DURING THE PREGNANCY OF THIS CHILD:

____Vitamins
____Over-the-counter
____Home remedies
____Minerals
____Hormones
____Antibiotics
____Tranquilizers
____Antihistamines
____Diet pills
____Aspirin
____Marijuana
____Other illegal drugs

PLEASE CHECK IN THE BOXES WHERE THIS CHILD'S BLOOD RELATIVES HAVE HAD ANY OF THE FOLLOWING:

	Child's Sisters	Child's Brothers	Natural Mother	Natural Father	Mother's Family	Father's Family
Seizure disorder						
Diabetes						
Mental retardation						
Cerebral palsy						
Other neurological diseases						
Heart disease						
Bone or joint disease						
Muscle disease						
Thyroid disease						
Down's syndrome (mongolism)						
Sickle cell anemia						
Vision problems						
Lung disease						
Allergies						
Kidney disease						
Slow learning						
Hearing problems						
Physical handicaps						
Cancer						
Tumors						
Venereal disease (V.D.)						
Other (list)						
_____						
_____						
_____						
_____						

I. MEDICAL (cont.)

How many months was the mother pregnant? _____

Did the doctors consider this child premature? _____

What was his/her birth weight? ___lbs.___oz.

How many hours were you in labor? _____

Was this child born in a hospital Yes___ No____

What type of delivery did you have? ___head first
___breech
___C-section

Were instruments (forceps) used to deliver the baby? Yes___ No___

Was this child a twin? Yes___ No____

At what age was this child discharged from the hospital after birth? _____

Did child breathe immediately at birth? Yes___ No____

Did child require oxygen after birth? Yes___ No____
For how long? _____

Was child on respirator (breathing machine) after birth? Yes___ No____
For how long? _____

Did child have any operations before he/she went home? Yes___ No____
If yes, what operations? _____
_____
_____

Was baby in incubator? Yes___ No____
If yes, for how long? _____

Was baby yellow after birth? Yes___ No____

Was baby blue after birth? Yes___ No____

Has child lost skills or abilities he/she once had? Yes___ No___

At what age did this child get his/her first tooth? _____

How many teeth does child have now? _____

PLEASE NOTE WHICH OF THE FOLLOWING CONDITIONS THIS CHILD HAS HAD:

_____Three-day measles
_____Chicken pox
_____Measles (10-day)
_____Scarlet fever
_____Polio
_____Ear infection
_____Pneumonia
_____Meningitis, Encephalitis (brain infection)
_____Anemia
_____Pain when passing urine or wetting diaper
_____Blood in urine or on diaper, panties or sheet
_____Accidental poisoning
_____Heart disease or trouble
_____Kidney trouble
_____Broken bones
_____Rheumatic fever
_____Liver disease (hepatitis)
_____Earaches
_____Draining of ears
_____Trouble seeing well
_____Trouble hearing well
_____Crossing eyes
_____Toothaches
_____Dental cavities
_____Frequent sore throats
_____More than 3 colds a year
_____Trouble breathing
_____Constant running nose
_____Blue spells
_____Frequent coughing
_____Frequent vomiting after eating
_____Frequent diarrhea
_____Frequent constipation
_____Tuberculosis
Other_____
_____
_____

I. MEDICAL (cont.)

c-8

DID YOUR CHILD RECEIVE THE FOLLOWING IMMUNIZATIONS (BABY SHOTS):

DPT (triple shot)	No___	Yes___	Date or Age_____
Polio Vaccine			
shots (Salk)	No___	Yes___	Date or Age_____
mouth (Sabin)	No___	Yes___	Date or Age_____
Measles Vaccine	No___	Yes___	Date or Age_____
German Measles	No___	Yes___	Date or Age_____
Mumps Vaccine	No___	Yes___	Date or Age_____
Tuberculin Test	No___	Yes___	Date or Age_____
Small Pox	No___	Yes___	Date or Age_____

Was he/she sick after any of these shots? No___Yes___

II. FEEDING AND NUTRITION

Does child require tube feeding? Yes___No___

Was child breast fed? Yes___No___

Does child drink from a bottle or a cup? Bottle___Cup___

If weaned from bottle and breast, at what age? _____

Does child hold his own cup to drink? Yes___No___

What texture of food does child eat most often?

___Babyfood
___Junior food
___Chopped table
___Regular table
___Finger food (crackers, cookies)

When you feed this child with a spoon:

a. does child close his/her lips to empty spoon? Yes___No___
b. do you scrape the spoon off the child's upper lip to empty spoon? Yes___No___
c. does child consistently push food out of his/her mouth with his/her tongue? Yes___No___
d. does child bite down on spoon and have difficulty letting go? Yes___No___
e. does child choke or gag on food frequently? Yes___No___
f. does child choke or gag on liquids frequently? Yes___No___

Approximately how long does an average feeding take? _____

Approximately how much solid food does the child eat in an average feeding? ___ tablespoons ___ cupfuls

Approximately how much liquid does child drink in an average meal? ___ bottles ___ ounces ___ cupfuls

Approximately how much milk does the child drink in an average meal? ___ bottles ___ ounces ___ cupfuls

Did you or do you enlarge the nipple hole in your child's bottle? Yes___No___

Did you feed child baby cereal or strained foods through an enlarged nipple hole from a bottle? Yes___No___

Does child swallow food whole that should be chewed? Yes___No___

How many meals does your child eat each day? _____

Does this child regularly eat between meals? Yes___No___

Does child constantly have his tongue out of his mouth? Yes___No___

Does child drool? Now___Past___ Never___

Who does most of the family grocery shopping? _____

Who prepares family meals most often? _____

In what positions does child eat his/her meals?

lying on his/her back? Yes___No___
leaning back in your arms? Yes___No___
reclined in infant seat? Yes___No___
supported or strapped in high chair? Yes___No___
sitting erect in high chair? Yes___No___

II. FEEDING AND NUTRITION (cont.)

In what positions does child eat his/her meals? (cont.)

sitting on booster seat at table? Yes___No___

sitting in adult chair at table? Yes___No___

sitting in especially designed or adapted chair? Yes___No___

Describe the above _____

_____

_____

CHECK WHICH OF THE FOLLOWING FOODS THE CHILD EATS AT LEAST ONCE A DAY:

fruits	_____	fruit juice	_____
vegetables	_____	milk	_____
green	_____	kool aid	_____
yellow	_____	jello water	_____
leafy	_____	tea or coffee	_____
meat	_____	soda pop	_____
cheese	_____	peanut butter	_____
eggs	_____	others	_____
cereal	_____	_____	
bread, cookies	_____	_____	
crackers,	_____	_____	
tortillas	_____	_____	
beans	_____	_____	
candy	_____	_____	

III. MOTOR DEVELOPMENT

Does child's body or any body part feel stiffer than you think it should? Yes___No___

Does child's body or any body part feel weaker or floppier than you think it should? Yes___No___

Does child change from feeling stiff sometimes to floppy other times? Yes___No___

Does child seem double jointed? Yes___No___

CHECK YES IF CHILD CAN DO THE FOLLOWING THINGS AND NOTE THE APPROXIMATE AGE AT WHICH HE/SHE BEGAN DOING IT:

Holds head erect and steady when you hold him/her? Yes___No___Age___

Holds head up when lying on stomach? Yes___No___Age___

Sits without outside support? Yes___No___Age___

Moves about on floor on stomach? Yes___No___Age___

Rolls from stomach to back? Yes___No___Age___

Rolls from back to stomach? Yes___No___Age___

Crawls on hands and knees? Yes___No___Age___

Gets self into sitting position? Yes___No___Age___

Pulls self to standing holding onto furniture? Yes___No___Age___

Takes steps without holding on? Yes___No___Age___

Walks steadily? Yes___No___Age___

Runs? Yes___No___Age___

IV. SENSORY DEVELOPMENT

CHECK WHETHER YOUR CHILD DOES THE FOLLOWING THINGS NOW, DID IN THE PAST, OR NEVER DID:

Repeatedly lifts head, arms and legs off floor and "rocks on tummy" Now___Past___Never___

Assists you when pulling him up to sitting by bringing his/her head forward and bending arms Now___Past___Never___

Brings hands and feet together and plays with them on his/her back Now___Past___Never___

Rocks repeatedly back and forth on hands and knees Now___Past___Never___

Rolls over and over to get to places Now___Past___Never___

Enjoys playing in rough and tumble ways with other children and adults Now___Past___Never___

IV. SENSORY DEVELOPMENT (cont.)

c-10

Protects self with arms when falling Now___Past___Never___

Uses both arms and legs well together Now___Past___Never___

Takes everything to his/her mouth as a means of exploring Now___Past___Never___

Plays with his own body parts (e.g., tummy, toes, genitals, etc.) Now___Past___Never___

Spends time repeatedly exploring objects in his/her environment (e.g., push pull, close open, poke with finger, rub, etc.) Now___Past___Never___

Cries when falls and hurts self Now___Past___Never___

Walks stiffly or awkardly after walking alone at least 6 months Now___Past___Never___

Seems fearful of bumpy or uneven ground after walking alone for at least 6 months Now___Past___Never___

Stands or walks on toes frequently Now___Past___Never___

Falls frequently or easily Now___Past___Never___

Shifts weight constantly. Can't seem to sit or stand still Now___Past___Never___

Gets "sick" when tossed around Now___Past___Never___

Usually leans on objects or lies down when playing Now___Past___Never___

Seems very weak when doing some things but very strong at others Now___Past___Never___

Constantly "forgets" from day to day how to do things Now___Past___Never___

Has poor posture, slouches Now___Past___Never___

Shows shakiness in fine movements Now___Past___Never___

Refuses to run or be moved quickly Now___Past___Never___

Scoots on bottom to get places Now___Past___Never___

Is very clumsy Now___Past___Never___

Sits and rocks self repeatedly Now___Past___Never___

"Gives up" or gets frustrated easily Now___Past___Never___

Frequently stiffens arms and legs in unusual way Now___Past___Never___

Bangs his/her head repeatedly Now___Past___Never___

Only hits or throws toys Now___Past___Never___

Ignores toys Now___Past___Never___

Moves constantly from one object to another randomly without playing with them Now___Past___Never___

Shows aggressive behavior for no reason Now___Past___Never___

Becomes easily upset and takes a long time to calm down Now___Past___Never___

Responds very passively to things or people around him/her (does not play, look around or reach for) Now___Past___Never___

Dislikes being handled; prefers to be left alone Now___Past___Never___

Pulls away or becomes upset when approached quickly Now___Past___Never___

Violently fights having face washed Now___Past___Never___

V. SPEECH AND LANGUAGE

Does child respond to your voice even when he/she cannot see you? Now___Past___Never___

Does child seem to hear the following:
- door slamming Now___Past___Never___
- telephone ringing Now___Past___Never___
- paper rattling Now___Past___Never___
- his own name Now___Past___Never___

Does child seem to hear better on some days than on other days? Now___Past___Never___

Has your child had a hearing test? Yes___No___
If yes, where? _____
_____

Does your child babble? (connect strings of sounds) Now___Past___Never___

Does child use single words, name object or people? Now___Past___Never___

If child uses only single words or two-word combinations, how many words does he/she use?
- fewer than 10 words? Yes___No___
- 10 to 25 words? Yes___No___
- 26-50 words? Yes___No___
- over 50 words? Yes___No___

Does child use some word combinations? Yes___No___

Does child leave words out of sentences? Now___Past___Never___

Does child stutter? Now___Past___Never___

Does child receive speech therapy? Now___Past___Never___

VI. LEARNING

Does your child presently attend any infant stimulation, preschool or school program? Yes___No___
If yes, is it a regular classroom or a special program of some kind?
- regular classroom Yes___No___
- special program Yes___No___

At what age did child first attend a preschool or school program? _____

Does child resist going to school in the morning? Yes___No___

If there are grades, what grade is child in now? _____

Does child's school use letter or number marks for grading achievement?
- letter marks Yes___No___
- number marks Yes___No___
- other_____ Yes___No___

If school uses letter or number marks for grading, what mark does your child get most frequently? _____

Has child ever repeated a grade? Yes___No___
If yes, what grade? _____

Has child's teacher ever suggested that he might have a learning problem? Yes___No___

Does child play with toys? Yes___No___

Does child watch television? Yes___No___

Does child feed self with fingers? Yes___No___

Does child feed self with spoon? Yes___No___

VII. PERSONAL CARE

Does child still wear diapers? Yes___No___
How often? _____

If child wears training pants, does he/she have accidents? Yes___No___

Do you feel you and the child are ready for toilet training? Yes___No___

Do you have a potty seat where the child could sit comfortably? Yes___No___

VII. PERSONAL CARE (cont.)

Does child stay dry at least 2 hours at a time? Yes___No___

Does child ever let you know when his diaper is wet or dirty? Yes___No___

Does child have his/her bowel movement at regular times every day? Yes___No___

Does child wet his diaper at regular times every day? Yes___No___

Does child hold his/her arm or leg out for you to put clothing on while you are dressing him? Yes___No___

Does child take off any piece of clothing by himself? Yes___No___

Does child put on any piece of clothing by himself? Yes___No___

Does child brush his/her teeth? Yes___No___
If yes, does he/she do it every day? Yes___No___
If no, do you brush his/her teeth for him/her? Yes___No___
Everyday? Yes___No___

Has child ever been to a dentist? Yes___No___

VIII. BEHAVIORAL

Does child get along with other children? Yes___No___

Does child avoid other children? Yes___No___

Does child cling to you around strangers? Yes___No___

Do you feel the child is hyperactive? Yes___No___

Does child let you know his/her wants? Yes___No___

Does child seem to understand what you say to him? Yes___No___

Who does most of the disciplining of this child?
mother? Yes___No___
father? Yes___No___
babysitter? Yes___No___
other? specify _____
_____

For whom does your child behave best? _____

Does child's mood sometimes change without any apparent reason? Yes___No___

Does child help with any jobs around the house? Yes___No___

IX. SOCIAL

Is English usually spoken in the child's home? Yes___No___
If no, what language is usually spoken? _____
What other languages are spoken in the home? _____
_____

Does child sleep in same room as the parents? Yes___No___

Does child sleep in same bed as parents? Yes___No___

Do you feel your housing is adequate for the health and safety of your children? Yes___No___

Does one of the child's parents have steady employment? Yes___No___

Do you have major outstanding debts that are putting a large strain on your family budget or finances? Yes___No___

Do you feel you have enough money to buy adequate food for your family? Yes___No___

Do you feel you need help planning how to spend and save your money? Yes___No___

IX. SOCIAL (cont.)

Does your family get food stamps? Yes___No___

Do you get additional money from other sources than your wages? Yes___No___
- investments? Yes___No___
- child support or alimony Yes___No___
- social security? Yes___No___
- other? specify? _____
  _____

Do you ever leave the child with a babysitter so you can go out by yourselves? Yes___No___

Do you have difficulty finding an adequate babysitter? Yes___No___

Have you had to change your child's babysitter more than 3 times in the last 6 months? Yes___No___

Who spends the most time taking care of this child? _____

Is your child fun to play with? Yes___No___

At what age level do you feel this child is functioning? _____

Do the child's parents have arguments about his condition or care? Yes___No___

Do you have arguments with family relatives (grandparents, aunts, uncles, etc.) about his/her condition or care? Yes___No___

Do your other children resent the attention this child gets? Yes___No___

Does the care for this child make it difficult for you to give adequate attention to your other children? Yes___No___

Have there ever been any legal actions involving this child? Yes___No___

Does the care of this child make any health problems of the father worse? Yes___No___

Have any family members had psychiatric or mental problems? Yes___No___

Does either parent have any physical disability that makes it difficult to care for this child? Yes___No___

Do any family members drink too much alcohol (beer, wine, etc.)? Yes___No___

Do any family members abuse or overuse drugs? Yes___No___

CENTRAL ARIZONA CHILD EVALUATION CENTER
200 North Curry Road
Tempe, Arizona 85281
Telephone: 244-9471 Ext. 333

I, as parent and/or legal guardian of , hereby give permission to the Central Arizona Child Evaluation Center to:

1. Videotape, photograph or take a motion picture of the child under study for use by CACEC staff.

Parent's Signature Date

I, as parent and/or legal guardian of , hereby give permission to the Central Arizona Child Evaluation Center to:

2. Have in attendance at the parent/staffing conference:

   a. Professionals involved with the child, such as:

	Parent's Signature	Date
i. School Personnel		
ii. Physicians		
iii. University Students/ Faculty		

I, as parent and/or legal guardian of , hereby give permission to the Central Arizona Child Evaluation Center to:

3. Release the records, or any part thereof, of , to any consultants as recommended in the evaluation and approved by the parents. It is understood that this information is confidential and will be treated accordingly.

SEND TO:	Parent's Signature	Date
NAME _____ ADDRESS _____ CITY & STATE _____ ZIP CODE _____		
NAME _____ ADDRESS _____ CITY & STATE _____ ZIP CODE _____		
NAME _____ ADDRESS _____ CITY & STATE _____ ZIP CODE _____		
NAME _____ ADDRESS _____ CITY & STATE _____ ZIP CODE _____		

ARIZONA DEPARTMENT OF HEALTH SERVICES

Division of Family Health Services

RAUL H. CASTRO, Governor
SUZANNE DANDOY, M.D., M.P.H., Director

Dear

RE:
Father's Name: OUR CASE NO.: BD:
Mother's Name: Military No.:

This child has been referred to this Center for a total evaluation of development. We understand that you have known this patient and our staff would appreciate a summary of pertinent information from your files. Checked below is the information which will be of help to us in our study.

- [ ] Mother's maternal history and delivery records.
- [ ] Prenatal care of mother (Questionnaire enclosed).
- [ ] Newborn and nursery record.
- [ ] School observation (Questionnaire enclosed).
- [ ] Psychological report.
- [ ] Medical treatment.
- [ ] Any other record of treatment.

I, hereby authorize

Name _____ Address _____

_____ Zip Code _____
City State

to furnish to the Central Arizona Child Evaluation Center, its physicians, dentists, nurses, and employees, any and all information in their possession relating to medical findings, treatment and records of the above-named patient.

_____
Signature of Parent/Legal Guardian Date

Thank you for your early reply which will enable us to start the child's workup.

Sincerely,

Central Arizona Child Evaluation Center
Phone: 244-9471, Extension 333

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lm
CACEC 4
2/24/77

Arizona Children's Hospital 200 North Curry Road Tempe, Arizona 85281

CHILD EVALUATION CENTER

QUESTIONNAIRE: PRENATAL CARE OF MOTHER

Mother's Name _____
CEC Patient's Name _____
Date of Birth _____

1. Was this a wanted pregnancy? Yes No

2. Has this mother received birth control medication? Yes No

3. When did the mother seek medical care? First trimester Second trimester

   Third trimester

4. Was the mother placed on usual prenatal vitamins? Yes No If so, do you think she took them as prescribed? Yes No

5. Was the mother on the usual prenatal mineral supplement, such as Fe, Ca, etc.?
   Yes No

6. (a) Was the mother anemic during pregnancy? Yes No
   (b) If so, what was the duration of anemia?
   Short period Throughout pregancy
   (c) How severe was the anemia? Mild Moderate Severe
   (d) Was supplemental iron given? Yes No

7. Was nausea and/or vomiting a problem? Yes, first part of pregnancy
   Yes, throughout pregnancy No

8. Do you think the mother had good eating habits throughout pregnancy?
   Yes No

9. Was the mother placed on a weight-reduction diet during pregnancy? Yes
   No

10. Were there other problems? Yes No

    Toxemia

    Bleeding

    Diabetes

    Infections

    Medications

    Please elaborate.

11. Is there any additional information you consider pertinent?

MCHD CE:18 12-69

SCHOOL OBSERVATION FORM d-3

Date Sent: _____
Date Received: _____
Date: _____ Birthdate: _____

_____
Name: (Last) (First) (Middle)

Address: _____ Phone #: _____ City _____ State _____

School: _____ Director's Signature _____
Teacher's Signature _____
School Address: _____ Date: _____

SCHOOL HISTORY:

Date entered your school _____
Previous school attended _____
Attendance (this year): Days Absent _____
Number of days per week in class _____
Number of hours per day _____

PHYSICAL DATA:

Describe any difficulties in:
Hearing: _____

Vision: _____

Motor Control: _____
_____
_____

Does the child receive any special therapies (physical therapy, speech therapy, etc?) _____

If yes, where and how often? _____

General Health and Physical Appearance: _____
_____
_____
_____

Please circle the response to each question which best describes this child.

SOCIALIZATION:

In terms of relating to other children, is this child's play best characterized as:

1. Isolate?
2. Parallel?
3. Cooperative, interactive?

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CACEC 11-b
3/9/77

How long is the child able to occupy himself appropriately with toys or instructional materials?

1. Not at all--needs constant adult supervision and direction
2. 5 minutes approximately
3. 10 minutes approximately
4. 15 minutes approximately
5. 15 to 30 minutes approximately

Does the child participate in teacher-directed group activities such as story-time or music without being disruptive?

1. Yes 2. No

Please give an example or two of the type of toys or play activities the child seems to enjoy most:

_____ _____ _____

Is there an anything about this child's social development which is of particular concern? 1. Yes 2. No

What type of behavior causes your concern?

1. Overly aggressive
2. Excessively dependent on adult attention and care
3. Usually shy and/or withdrawn
4. Seems unaware of others in the environment
5. Actively avoids interaction with adults and/or children
6. Other: specify _____

LANGUAGE:

Is the child able to follow simple one-step directions?

1. Yes 2. No

Do you consider the child's understanding of language to be:

1. Appropriate for age
2. Poor for age
3. Minimal or nonexistent

Which of the following best characterizes the child's verbal language?

1. No vocalization
2. Babbling
3. Complex jargon
4. Single words
5. Two and three word combinations
6. Sentences

If the child talks, is his speech

1. Usually clear, easily understood
2. Usually understandable to someone familiar with him
3. Very difficult to understand

If the child does not talk, does he have a gesture language for communication?

1. Yes 2. No

MOTOR SKILLS:

Can the child

1.	Sit unsupported?	Yes	No
2.	Walk independently?	Yes	No
3.	Walk up and down stairs?	Yes	No
4.	Jump from a low step or box without falling?	Yes	No
5.	Hop on one foot?	Yes	No

Does the child

1. Scribble or draw with pencil crayon? Yes No
2. Hold pencil or crayon with an adult grasp? Yes No
3. Cut with scissors? Yes No
4. Do fine manipulative activities such as placing small pegs in a pegboard, stringing beads? Yes No

READINESS:

Can the child copy a

1. Vertical line
2. Horizontal line
3. Cross
4. Circle
5. Square
6. Triangle

Has he established hand dominance? Yes No
Please circle: left right

Can he name body parts? Yes No
Can be point to body parts on command? Yes No

Can the child give you "just one" of something when asked? Yes No
give you "two"? Yes No
give you "three"? Yes No

Does the child identify his own name when printed on paper? Yes No

Can the child sort objects by

1. Color? Yes No
2. Shape? Yes No
3. Size? Yes No
4. Function? Yes No

Is the child interested in looking at books? Yes No
Does he name the pictures? Yes No
Does he name or talk about the actions in pictures? Yes No

Does the child demonstrate simple one-to-one correspondence (e.g., put a cookie on each napkin?) Yes No

Does the child listen attentively to a short story? Yes No
Is the child able to answer simple questions about the story, e.g., what is the boy doing? Yes No

Does the child show interest in printed words by asking what a sign or poster says or perhaps by asking what you are writing? Yes No
Does the child "pretend" or write, that is, does he make marks with crayons, chalk, or pencil which he identifies verbally as words? Yes No

Have you seen any evidence of significant perceptual problems in this child?
Yes No

ADDITIONAL COMMENTS:

_____
_____
_____
_____
_____

lm
CACEC 11-d
3/9/77

e-1

ARIZONA DEPARTMENT OF HEALTH SERVICES

Division of Family Health Services

RAUL H. CASTRO, Governor
SUZANNE DANDOY, M.D., M.P.H., Director

Dear

The Central Arizona Child Evaluation Center, CACEC, has a policy of open records to parents or guardians. Anytime you want to review them, just call and an appointment will be immediately set up for your review.

If you desire, a staff person could be with you to discuss the records.

Sincerely,

Richard W. Carroll, Ph.D., Acting Director
Central Arizona Child Evaluation Center
Phone: (602) 244-9471 Extension 333

DBO:lm

CACEC 6
2/23/77

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Problem Number	Date Started	Date Discontinued	Problem Statement and Assessment Questions	Responsible Staff

Case Developer: _____ _____, Pediatric Nurse Practitioner

Problem Statement Form

Client's Name _____ B.D. _____ Case No. _____ Problem No. _____

Evaluation Date _____ Report Prepared By _____ Position/Title _____ Date _____

Assessment Participants _____ _____ _____ _____

Problem Statement:

Summary of Evaluation Findings:

Remediation Plan and Methods:

Follow-through Recommendations:

PROBLEM #	PROBLEM MANAGER: PROBLEM TEAM:
ASSESSMENT STRATEGY:	
SUMMARY OF PRINCIPAL FINDINGS:	

Case Developer's Name: _____ _____
Pediatric Nurse Practioner
Case Manager's Name: _____ _____,M.S.W.

Child's Name: _____ _____
CACEC File Number: _____

REMEDIATION OR CORRECTION PLAN:

PRESCRIPTION FOR REMEDIATION OR CORRECTION:

FOLLOWALONG SCHEDULE AND PLAN

WHO:

INTERVAL:

STRATEGY:

SUMMARY OF ASSESSMENT ACTIVITIES AND FINDINGS:

PARENT REACTIONS/COMMENTS FOLLOWING CONFERENCE:

SIGNATURES OF PARTICIPANTS:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Child's Name:
CACEC File Number:

APPENDIX B

Functional Procedures, Citizen's Advisory Council

By-Laws, CACEC Executive Board

FUNCTIONAL PROCEDURES

Citizens Advisory Council to CACEC - (Central Arizona Child Evaluation Center)

I. PURPOSES:

The purposes of the Citizens Advisory Council to CACEC are:

A. Monitor satisfaction and dissatisfaction of parents and agencies making referrals.

B. Collect information on consumer accessibility problems such as scheduling, transportation, and time it takes for evaluation.

C. Present suggestions to CACEC as to needed parent training, improvement in service, accessibility problems needing solution.

D. Assist in publicizing services offered, especially in getting information to medical profession.

E. Assist the Center in providing adequate initial information to clients; i.e., packet with all pertinent information on the Center.

F. Review any proposed changes in CACEC services and give consumer input.

G. Help CACEC develop follow-up services; e.g., use of volunteers to go into a home and talk to families about the Center and the evaluation.

H. Monitor effectiveness of teamwork between CACEC staff members by site visit.

II. ORGANIZATION:

A. Members

The Committee shall be composed of at least 9 members: At all times 51% of the members shall be parents of the developmentally disabled. Others may be from related professions or other interested persons.

B. Terms of Membership on Council:

Members shall serve on the Council for:

a. period not exceeding 5 years.
b. when member resigns a new member shall be appointed by a majority vote of the Council.

c. Members are expected to attend meetings. A member will be dropped from the Council after three consecutive absences.

C. Officers:

The Citizens Advisory Council to CACEC shall elect a Chairperson, Vice-Chairperson, and a Secretary.

1. The Chairperson shall serve for a 6-month period, and shall attend the Executive Board Meetings of the CACEC as a voting member.

2. The Vice-Chairperson shall serve for a 6-month period and then serve as Chairperson for a 6-month period. A new Vice-Chairperson shall be elected each 6 months.

3. The Secretary shall be elected for a 6-month period and shall record minutes and maintain orderly records of Advisory Council business.

D. Meetings:

The Advisory Council shall meet at least six times a year. Meetings are open to the public. The meetings will be conducted in accordance with Roberts Rules of Order. These rules may be suspended by majority consent.

III. REPORTING TO CACEC:

A. The Chairperson will report to the Executive Board of CACEC each month.

B. A written summary of the Advisory Council's monitoring program and records will be submitted each 6 months (at end of each chairperson's term).

CACEC EXECUTIVE BOARD
BY-LAWS

STATEMENT OF PURPOSE

The Central Arizona Child Evaluation Center (CACEC) Executive Board represents the CACEC service, consumers and the major State agencies serving handicapped children. The Board provides ongoing periodic review and policy setting for Central Arizona Child Evaluation Center.

BY-LAWS

I. MEMBERSHIP

A. Composition

1. Membership on the Executive Board of the CACEC shall consist of appointments from the:
   a. Arizona Department of Health Services (2 seats).
   b. Arizona Department of Education (2 seats).
   c. Arizona Department of Economic Security (1 seat).
   d. CACEC Consumer Advisory Council (1 seat - which will be periodically rotated).
2. Each sponsoring agency shall advise the Board in writing of the name of its representative and authorize that representative to officially represent the appointing agency on matters of CACEC policy.
3. Each member present, except those ex-officio, shall have one vote.

B. Ex-officio Membership

The director of CACEC and the appointed representative of Southwest Regional Resource Center (SRRC) are ex-officio members. The Board may appoint other ex-officio members.

C. Proxies

Each member may designate a proxy to attend Board meetings, in his/her absence. Such designation to be received in writing or by telephone. When designation is via telephone, written confirmation must be received within 24 hours. The proxy has the same membership rights as the member he/she is replacing.

D. Quorum

A quorum consists of four voting members of the Executive Board membership or their designated proxies. No action of the Board shall be valid in which there is not a quorum present.

II. MEETINGS

The Board shall meet monthly at times and locations established by the Board. Special meetings of the Board may be called by the chairperson or a majority of the Board members and may be held at any time upon thirty-six hours oral or written notice.

Attendance at a special meeting by the Board by a member entitled to notice shall constitute a waiver of notice of the special meeting unless he attends for the express purpose of objecting to the transaction of business at such meeting on the ground that the meeting was unlawfully called or convened. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

III. PROCEDURES FOR AGENDA/MINUTES

One week prior to next scheduled monthly meeting, the tentative agenda and previous meeting's minutes shall be distributed to all Board members and consumers on the current mailing list. The agenda can be changed up to the day of the meeting and items added prior to the start of the assembly.

IV. RESPONSIBILITIES

A. The Executive Board will review annually the effectiveness of the CACEC program. Such review will be completed no later than April 1 of each year. This review will be conducted under a set of objective criteria adopted by the Board at the October meeting.

B. The Executive Board will annually select its chairperson and vice-chairperson from among voting members of the Board, during the July meeting of each year. The effective date to take office will be the August meeting.

Any officer may be re-selected for addtional terms in the same office.

C. The Executive Board will define the duties of the chairperson and the vice-chairperson.

1. The chairperson shall preside at and be responsible for the agenda of all meetings of the Executive Board.
2. The chairperson shall be responsible for the enforcement of the Executive Board By-Laws.
3. In the absence of the chairperson, the vice-chairperson shall assume the duties and authority of the chairperson.

D. The Executive Board may assist the administrating agency by:

1. Recommending job qualifications deemed appropriate to the position of CACEC director.
2. Reviewing with the administrating agency, the job description for the position of director.
3. Acting in an advisory capacity on the selected applications for that position.

V. COMMITTEES

Standing and special committees may be created by the Board when deemed necessary and appropriate. Committee members shall be appointed by the chairperson and need not be members of the Board.

VI. AMENDMENTS

Amendments to these By-Laws may be recommended by the Board to the sponsoring agency heads at any time.

VII. PARLIAMENTARY AUTHORITY

Procedural disputes shall be resolved by reference to the then-current edition of Roberts Rules of Order.

VIII. APPROVAL

These By-Laws and Amendments hereto are effective when signed by the directors of the sponsoring agencies. (D.H.S., A.D.E., D.E.S., and the chairperson of the CACEC Consumer Advisory Council.)

Authorized Signatures:

Arizona Department of Health Services	Date
Arizona Department of Economic Security	Date
Arizona Department of Education	Date
CACEC Consumer Advisory Council	Date

hsw/12/8/76

APPENDIX C

Case History

S1

Case History

Child: Y _____ _____

Age: 6 years 6 months

Presenting problem: Question of appropriate placement in school. Limited verbal language. High activity level and distractibility.

Background information:

Y had been recognized early as having developmental disabilities. He had attended special preschool programs from the age of three, and his mother felt that he had progressed well in those programs. On attaining the age of public school attendance, he was tested by school district personnel and found to be functioning in the moderate range of retardation intellectually and adaptively. He was assigned to a special education class for the trainable mentally handicapped. The appropriateness of the placement was questioned on the basis of the child's intense interest in numbers and letters and his apparent ability to read a number of words.

Interdisciplinary assessment:

An initial assessment was done based on the following studies: pediatric examination, neurologic examination, formal psychological testing, speech and language evaluation, and educational assessment.

In discussing the results of these initial studies, the staff noted striking inconsistencies in Y's apparent abilities. The formal psychological test was in agreement with testing done in the school district, indicating a mental age of slightly less than three years and intellectual ability in the moderate range of retardation. Yet academic readiness testing revealed many skills significantly more sophisticated than this. The latter results were substantiated by the child's spontaneous behaviors with all examiners.

Three factors were considered as possibly contributing to such striking inconsistencies.

1. Extreme distractibility, observed in all situations.
2. Expressive language abilities quantitatively no higher than the 20-month level, but with characteristics of disordered rather than merely delayed language.
3. Skull x-rays suggestive of possible hydrocephalus. The child had been noted as having a large head at birth and had been followed for possible hydrocephalus for the first

six months of life. There had never been any clinical indication of hydrocephalus until the present x-rays.

Based on these factors, the following activities were planned:

1. Discuss with parents a possible trial of behavior modification medication for improved attention and concentration.
2. Do further psychometric testing using a strictly nonverbal instrument.
3. Obtain a computerized brain scan to rule out developing hydrocephalus.
4. Through occupational therapy evaluation, assess possible defects in sensory integration and their relationship to poor attention and concentration.

The parents were extremely reluctant about a trial of medication, and this was deferred. On the Leiter International Performance Scales, Y achieved a mental age of three years ten months. This was much more commensurate than previous testing with demonstrated academic skills and clearly indicated the potential for functioning at the educable rather than the trainable level. The brain scan showed normal ventricles, eliminating the concern for hydrocephalus. Sensory integration assessment indicated hypersensitivity to sensory stimuli, particularly tactile. This appeared to be a major factor in problems of distractability and overactivity.

Interpretation of findings and habilitation plan:

All of the assessment findings were reveiwed when the team members met with the parents and school personnel. The major conclusion was that Y was a child with the potential for functioning at least at the educable level. However, realization of that potential was impeded by specific, identified multiple disabilities. Disordered language development, with the resulting lack of an effective communication system, was particularly handicapping.

The consensus of the group, including the parents, was that although Y's placement was technically incorrect according to the nonverbal intelligence measure, it was appropriate to his specific needs and overall consistent level of functioning. The trainable classroom included total communication, plus individual language therapy. The class size was smaller than it would have been in an educable program and permitted more concentrated individual work in deficit areas such as sensory integration. It was felt that Y's limited language, his attentional problems, and his poor interaction with other children would seriously limit his chances of succeeding in a class for educable mentally handicapped children. The outcome was to continue Y's placement in the trainable program, with careful monitoring and periodic reevaluations at CACEC. Movement to an educable program would be possible when appropriate.

APPENDIX D

Frequently Used Instruments

Instruments Frequently Used
in Assessing Children at CACEC

Alpern-Boll Developmental Profile

Amiel-Tison Neurological for the First Year of Life

Ayres California Tests of Sensory Integration

Bayley Scales of Infant Development

Carrow Elicited Language Inventory

Carrow Test for Auditory Comprehension of Language

Columbia Mental Maturity Scale

Detroit Tests of Learning Aptitudes

Illinois Test of Psycholinguistic Abilities

Jedrysek Psychoeducational Evaluation of the Preschool Child

Leiter International Performance Scales

Milani-Comparetti Motor Development Scale

Northwestern Syntactic Screening Test

Peabody Individual Achievement Test

Photo Articulation Test

Portage Guide to Early Education

Preschool Language Scale

Pupil Record of Educational Behavior

Receptive Expressive Emergent Language Scale

Sequenced Inventory of Communication Development

Stanford Binet Intelligence Test

Utah Test of Language Development

Uzgiris and Hunt: Assessment in Infancy: Ordinal Scales of Psychological Development

Weschler Intelligence Scale for Children - R

APPENDIX E

Questions Educators Should Ask Following Assessment

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Questions Educators Should Ask the Doctor

1. Are the child's intellectual problems due to some medical cause?
2. Is it treatable?
3. Are the child's physical problems on a medical basis (including vision, hearing)?
4. Treatable?
5. Are the child's behavioral problems of a medical cause?
6. Treatable?
7. Are there specific needs for appliances (e.g., glasses, hearing aid, braces)?
8. Is the family care adequate?
9. Are management problems contributing to the difficulties?
10. Is there significant family history concerning this condition?
11. Is any special management needed in classroom (e.g., location of child; speaking to child)?
12. Can he play without restriction with other children?
13. Is he difficult to manage and should discipline be specialized?
14. Do the parents need special support?
15. Would you like to receive a description of his classroom and/or learning problems?
16. May I receive any recommendations you have?
17. Is he on medication? If so, should any special behaviors be expected? What should be done in the event these behaviors are observed?
18. If the problems have an emergency quality (e.g., convulsions) could you be called?

Questions Educators Should Ask the Psychologist

1. Did the child show deficits in all areas or in specific subareas? What were they?

2. Were the results of different instruments consistent? Are there discrepancies between academic, social and adaptive development?

3. What implementation for school curricula were noted from the assessment (e.g., academics, preacademics and prevocational)? And why?

4. What environmental adaptations facilitate learning and performance? What would these be (e.g., one-to-one or group training, self-contained centers, etc.)?

5. Can immediate training/educational objectives be recommended?

6. Were the findings considered valid and representative of the child's functioning level? Should further assessment be done? When? What assessment?

7. What major assets and liabilities were noted during the assessment? How might assets be used in programming? Liabilities minimized?

8. What, if any, resource/support services might facilitate the child's adaptation to the school environment/setting (e.g., physical therapy, speech therapy, etc.)?

Questions Educators Should Ask the Physical Therapist

1. Does the child have adequate independent head control to maintain normal eye contact with educational materials?

2. Does his head control depend on adapted positioning or straps in a chair? Please describe.

3. Does his sitting balance depend on adapted positioning or straps in a chair? Please describe.

4. At what level should visual materials be presented for him to maintain the best head and trunk control--above, below, or at eye level?

5. At what level should arm activities such as finger painting, writing or maniupulation be done--regular desk height, table at shoulder height, easel, or other?

6. What position changes should be encouraged during classroom hours to prevent deformities?

7. Is adaptive equipment needed for these positions? Please describe.

8. What are the deformities most in danger of developing?

9. Are there any activities that could make his control worse? Please describe.

10. Does he have normal feeling in all parts? If not, what precautions must be taken?

Questions Educators Should Ask the Audiologist

I. Diagnosis of the Hearing Loss and Initial Audiological Follow-up

A. Does the child have a hearing loss?
   1. What degree of hearing loss does the child have (mild, moderate, severe, profound)?
   2. What type of hearing loss does the child have?
      a. Is the hearing loss unilateral, bilateral symmetrical, or bilateral asymmetrical?
      b. What is the site of lesion of the hearing loss?
         1. Is the hearing loss conductive?
         2. Is the hearing loss sensorineural?
         3. Is the hearing loss mixed?
      c. How long has the child had the hearing loss? Is it acquired or congenital?
      d. Is there a known causal factor for the hearing loss?
      e. Is the hearing loss fluctuating, stable, or becoming progressively worse?
   3. What effect has the hearing loss had on the child?
      a. Is there a delay in speech and language development?
      b. Are there any behavioral or emotional problems associated with the hearing loss?

B. What is the appropriate follow-up procedure after the hearing loss has been diagnosed?
   1. If the hearing is sensorineural, is further audiological or otological testing necessary to rule out a retrocochlear site of lesion?
   2. Is a medical referral appropriate?
      a. Is the hearing loss usually correctable by surgery or medication and, if so, what type of audiological follow-up is necessary?
      b. To what type of physician should the child be referred?
   3. Is amplification appropriate?
      a. Who should conduct the hearing aid evaluation?
      b. What is involved in the hearing aid evaluation?
         1. What is the procedure?
         2. What is the evaluation fee?
         3. How long is the trial period?
      c. What is the appropriate hearing aid fitting?
         1. Will the hearing aid be an ear-level or body-worn hearing aid?
         2. Which ear should be fitted?
         3. Will the child need a binaural or monaural fitting?
         4. What is the appropriate type of earmold?
      d. Where will the hearing aid be purchased and what will be the approximate expense?

e. What financial resources are available to parents for the purchase of a hearing aid?
f. How well will the child be able to hear with amplification?
g. What is the role of the school and the classroom teacher in the orientation, usage, and care of the hearing aid?

4. Is hearing conservation indicated?
   a. Should the child make use of ear protection in all "noisy" situations?
   b. How often are audiological reevaluations necessary?
5. Is a speech and language evaluation or an overall developmental assessment of the child necessary?

II. Appropriate Education for the Hearing Impaired Child

A. In what type of classroom should the child be placed?
   1. Is a regular classroom setting appropriate?
      a. Is preferential seating necessary?
      b. Is speech therapy recommended?
      c. Is a resource teacher needed?
   2. Is enrollment in a "hard-of-hearing classroom" for full days necessary?
   3. Is a regular classroom for part of the school day and a hard-of-hearing classroom for the other part of the school day appropriate?
   4. What other options are available?

B. What information should the classroom teacher have concerning the child's hearing loss?

C. What information should the classroom teacher have concerning the child's amplification system?

D. Whose responsibility is it to check if the hearing aid is functioning adequately on a day-to-day basis?

E. When is it appropriate to mainstream hearing impaired children into regular classrooms?

III. Hearing Conservation in the School

A. What considerations are involved in setting up a school hearing screening program?
   1. What are the state guidelines concerning: (a) personnel needed, (b) type of screening test employed, (c) pass/fail criteria, (d) population of children screened, (e) necessary facilities and equipment, and (f) audiological and otological follow-up?
   2. Who should be in charge of setting up the hearing screening program?

B. How can the classroom teacher help in identifying hearing impaired children?